Universal Health Care Commission meeting

April 17, 2024

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Universal Health Care Commission

Agenda

Wednesday, April 17, 2024

2:00 – 5:00 PM

Hybrid Zoom and in-person meeting

Commission members:		
☐ Vicki Lowe, Chair	☐ Senator Emily Randall	☐ Representative Marcus Riccelli
☐ Senator Ann Rivers	☐ Estell Williams	☐ Mohamed Shidane
☐ Bidisha Mandal	☐ Jane Beyer	☐ Nicole Gomez
☐ Charles Chima	☐ Joan Altman	☐ Omar Santana-Gomez
☐ Dave Iseminger	☐ Representative Joe Schmick	☐ Stella Vasquez

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order • Welcome new member	1	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:05-2:08 (3 min)	Roll call	1	Mandy Weeks-Green, Boards and Commissions Dir. Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 02/02/2024	2	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:10-2:25 (15 min)	Public comment	3	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:25-2:55 (30 min)	FTAC updates • SB 5335 Whole Washington (presentation recording) • Considerations for actuarial analysis	4	David DiGiuseppe, Alternate FTAC Liaison
2:55-3:25 (30 min)	State agency report outs and 2024 legislative session updates	5	Commission members Evan Klein, Special Asst. for Policy & Legislative Affairs, Health Care Authority
3:25-3:30 (5 min)	Break		
3:30-4:50 (80 min)	Administrative Simplification – A Local Perspective • Commission discussion	6	Richard Rubin, Executive Dir., Washington Healthcare Forum Clinical Assistant Professor, Health Systems and Population Health, University of Washington
4:50-5:00 (10 min)	Next steps	7	Liz Arjun, Principal Health Management Associates
5:00	Adjournment		Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State

Tab 2

Washington State Health Care Authority

Universal Health Care Commission meeting summary

February 2, 2024

Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority (HCA)
2–5 p.m.

Note: this meeting was recorded in its entirety. The recording and all materials provided to and considered by the Commission is available on the Universal Health Care Commission webpage.

Members present

Vicki Lowe, Chair
Bidisha Mandal
Charles Chima
Dave Iseminger
Jane Beyer
Megan Matthews
Mohamed Shidane

Members absent

Senator Ann Rivers
Senator Emily Randall
Estell Williams
Joan Altman
Representative Joe Schmick
Representative Marcus Riccelli
Nicole Gomez
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:03 p.m.

Agenda items

Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed members to the sixteenth meeting.

Meeting summary review from the previous meeting

The Commission members voted by consensus to adopt the December 2023 meeting summary.

Public comment

Liz Murphy, WA Community Action Network, faces barriers to life-saving treatments due to their source of health care coverage. A single-payer health care system would reduce financial burdens and barriers to necessary care.

Cris Currie urged the Commission to refer to work by the Universal Health Care (UHC) Work Group to accelerate decision making and encouraged more discussion regarding direction, agenda-setting, and goal setting.

Lori referred to the UHC Work Group's recommendation to study Model A, urged the Commission to develop a timeline and benchmarks for their work, and to receive recordings of presentations in advance of meetings.

Adoption of 2024 workplan

The Commission will focus on developing recommendations to the Legislature on transitional solutions. Per the Commission's direction, FTAC will focus on universal health care design elements and will report findings to the Commission. **The Commission members present voted unanimously to adopt the 2024 workplan.**

FTAC updates: Guidance on Medicaid

Pam MacEwan, FTAC Liaison

FTAC surfaced pathways to include Medicaid in the universal system (FTAC's Memo begins at page 29 of today's meeting materials). FTAC's recommendations provide guidance to allow design work to advance, though Medicaid will need to be revisited over the course of the Commission's design work for the larger system.

First, FTAC recommends that the Commission consider pursuing Medicaid waivers and SPAs as needed to include Medicaid enrollees in Washington's universal health care system, details of which will need to be developed once benefits and services and other design elments are determined. Second, Medicaid payments are significantly lower than Medicare and commercial rates, though it is less clear whether increasing payments for certain practices will result in increased access for Medicaid patients. FTAC recommends that UHCC consider recommending a study to evaluate the impact of Medicaid rates on access to care for Washington Medicaid enrollees. Finally, administrative complexity has been cited by providers as a barrier to participating in Medicaid. FTAC recommends that in their transitional solutions work, the Commission consider paths to simplify administration for the Medicaid program which may help motivate provider participation in Medicaid.

State agency report outs

Commission members representing state agencies shared updates from the 2024 legislative session. Of note, actuarial work and economic modeling are underway on OIC's legislative Affordability Report (due Aug. 1), including a feasibility study on a global hospital budget model for at least one Washington county or area. Additionally, enrollment in qualified health plans (QHP) increased by 40 percent, including individuals whose Medicaid eligiblity was redetermined (post-public health emergency) and individuals newly eligible for QHPs through the state's 1332 waiver (QHP-eligible regardless of immigration status).

Presentation: Administrative simplification overview

David Cutler, Ph.D., Otto Eckstein Professor of Applied Economics, Dept. of Economics and Kennedy School of Gov't, Harvard University

Nikhil Sahni, Partner, McKinsey & Co., Fellow, Department of Economics, Harvard University

Dr. David Cutler and Nikhil Sahni shared findings from their 2021 study regarding what can be done now (and how) to make a material impact on administrative spending in health care within the context of the current US health care system. There is an estimated $950 billion (as of 2019) in annual administrative spending in the US health care system. However, reducing administrative spending will not be possible with any one solution or stakeholder alone. Research suggests that it will take sustained, continued effort by all health care stakeholders.

This analysis assumes that the US healthcare system will structurally stay as-is. Nearly two thirds of administrative spending is in private payers, hospitals, and physician groups. Levels of administrative spending varied by stakeholder. The study identified 30 actionable interventions that would result in $265 billion annual

savings which could be achievable in the next three years without affecting clinical/health outcomes or quality. Four keys to capturing this opportunity include making administrative simplification a strategic priority, committing to transformational change, engaging the broader partnership ecosystem, and allocating resources disproportionately. Reducing administrative spend is in part a matter of finding the right incentives for stakeholders, and in part demonstrating to stakeholders the gravity of the issue and actionable interventions.

There is no guarantee that cost savings will result in lower prices for consumers. This requires a policy lens, e.g., regulatory intervention. For a unified health care system, standardization and optimization is needed across all stakeholders and payer groups including self-insured employers, Medicaid and Medicare.

Presentation: Administrative simplification in Washington Medicaid

Christopher Chen, MD, Assoc. Medical Director, Health Care Authority (HCA)

HCA expanded the scope for the definition of administrative burden to include individuals the agency serves, e.g., individuals applying for assistance programs. Administrative burden is harmful to providers and patients and its reduction can be viewed as a tool to prevent structural racism and systemic inequities.

Several initiatives in this vein are underway at HCA, e.g., consideration of interventions like a centralized clearinghouse to reduce barriers to payment for smaller providers and increase representation in the Medicaid provider workforce. HCA is also leading the development of the Washington State Action Plan for Removing Barriers to Health and Human Services whose goal it is to develop a 20-minute application for clients to enroll in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), childcare, and Medicaid benefits. HCA also participates in the Multi-payer Primary Care Collaborative in the development of a new primary care model for the state. This model will align standards, provide practice supports, and offer payment models that balance provider flexibility with accountability which will reduce administrative burden for payers and providers and allow clinicians to focus on whole-person care for patients. The Commission can call out and lift these important kinds of initiatives in their annual report to the Legislature.

Direction for FTAC

Liz Arjun, Principal, Health Management Associates

FTAC assessed pathways to include Medicare, Medicaid, and self-insured employers in Washington's universal health care system (though further analysis is needed once benefits and services are determined). Covered benefits vary across coverage sources and work is underway to develop a tool to compare benefits. The Commission discussed some of the priorities for and approaches to benefit design, e.g., design an aspirational benefits package to address population health and then determine the cost, versus beginning with cost (which may change the outcome of the benefits package). What the state can afford may be a moving target. Having the average provider reimbursement rate across payers may help identify inefficiencies. The Commission pondered a two-tiered approach to coverage and benefits similar to other countries, e.g., offering a minimum essential benefits package without cost barriers. Plans offering additional benefits could be offered through the private market, introducing some cost-sharing, but which could perpetuate health inequities and disparities. The Universal Health Care Work Group (predecessor to the Commission) conducted modeling that may be helpful to estimate costs to the state to use Medicaid or other benefits packages as a benchmark.

Adjournment

Meeting adjourned at 5:04 p.m.

Next meeting

April 17, 2024

Meeting to be held on Zoom and in-person at HCA
2–5 p.m.

Tab 3

Public comment

Washington State Health Care Authority

Universal Health Care Commission

Written Comments

Received From January 20

Written Comments Submitted by Email

C. Currie 1

R. Collier 1

C. Currie 8

Additional Comments Received at the February Commission Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=WGFJu1i91E0

Public comments received since (January 19) through the deadline for comments for the April meeting (April 3)

Submitted by Cris Currie

2/6/2024

Cris Currie, on behalf of lots of discouraged observers. I hope this isn't news for any of you, but it needs to be out in the open and dealt with ASAP. This commission is stuck in neutral. It has not made a substantive decision regarding program design since it started some 25 months ago. It has been ignoring the accomplishments of the Work Group and, despite numerous requests, consistently avoiding laying out a long term work plan with a specific set of endpoints. Instead it has been spoon fed copious amounts of detailed background information by consultants who display no knowledge of single-payer health systems and who even tried to convince Work Group members that single-payer Option A is infeasible. Consequently members have had no time for discussion of presentation relevance to a single-payer system or for decision making, and they have no clear idea about where this is all leading. It's like playing football with no yard lines, side lines or goal posts. You can go through the motions of playing the game, but you can't keep score. The one objective that *has* been accomplished is that the motions are performed as slowly as possible.

In an effort to speed up the process, many of us successfully lobbied for a major 64% increase in funding for the Commission, but to date, there has been no accounting for how it is being spent. The numbers in the draft report were somehow left out the final report, with no explanation, and as taxpayers and advocates, we demand full and immediate accountability.

The February meeting was one of the worst yet, with an agenda that constituted more wheel-spinning as other topics were taken up before the previous topic was concluded. Several important decisions about eligibility are being left to the distant future so an illusion of progress can be maintained. Significant administrative simplification is not a transitional solution and can't be done in the presence of multiple, for-profit managed care organizations. And the need for Medicaid waivers can't be determined until a draft bill is finalized and discussions with CMMI are initiated.

Commission members need to make a course correction before things get any more embarrassing. Give the consultants the day off, and have a serious discussion about leadership, direction, agenda setting, timelines, poor attendance, goal posts, and the role of consultants and staff. If big changes don't happen soon, I fear the Commission will lose both its public and legislative support.

Public frustration and anger are growing exponentially with every Commission meeting, so I certainly hope these written comments are forwarded to the members as they come in, instead of sitting in a file until the meeting materials are sent out 2 months later. Commission members should also have an opportunity to respond to public comments during the meeting. Their perpetual silence is deafening. If the Commission does not start taking the public's complaints seriously, I fear they will soon lose both the public's and the legislature's support.

Cris

Submitted by Roger Collier
2/27/2024

February 27, 2024

Dear FTAC members --

I was encouraged that the UHCC at its last meeting recognized the obstacles facing inclusion of Medicare and ERISA enrollees within a universal State system and agreed at this time to exclude these groups.

(The UHCC also delayed consideration of providing supplemental coverage for Medicare and ERISA enrollees, but to do so fully would require some $5 billion in new funding for each of the two groups.)

This means that FTAC's recommendations for benefits will apply for the foreseeable future only to individuals and fully insured groups, and to Medicaid eligibles (although Federal approval of inclusion of the latter in a universal system may be dependent on demonstrating success with the former).

The UHCC's decision after two years is a major milestone, but further efforts to accelerate the process seem appropriate. In an attempt to clarify issues relating to benefits I have prepared the attached paper. I would be happy to discuss it with the committee.

Thank you,

Roger Collier

ROGER COLLIER rcollier@rockisland.com

SIX QUESTIONS FOR FTAC ON BENEFITS

ROGER COLLIER rcollier@rockisland.com

1. HOW DO WE DEFINE "BENEFITS"?

If we define benefits as services that enrollees are entitled to receive (perhaps with limitations), then are each of the following parts of the definition?

- Covered services
- Access to services (e.g. are they reasonably available?)
- Restrictions on provider and facility types
- Prior authorization requirements
- Limitations on services (e.g. frequency)
- Deductibles
- Copays and coinsurance
- Waiting periods (e.g. from date of enrollment)
- Retroactivity (e.g. as for Medicaid)

2. SHOULD ALL ENROLLEES HAVE THE SAME BENEFITS?

- Some mandated Medicaid benefits are not typical of most health insurance
- Should all Medicaid benefits be extended to all enrollees?
- Alternatively, if all Medicaid eligibles are included in the total enrollment, should their long-term-care benefits be segregated and not available to non-Medicaid enrollees?

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3. SHOULD THE SAME PAYMENT RATES AND RULES (FOR THE SAME SERVICES) BE APPLIED TO ALL PROVIDERS FOR ALL ENROLLEES?

- There are significant regional variations in providers' costs.
- "Universal financing" implies the same payment rules for all providers.
- This would likely mean payment increases for providers with many Medicaid eligibles and payment reductions for providers with mostly commercial patients. The risk is that the latter may prefer not to accept patients at the (new) lower rates.

4. SHOULD THERE BE A MORE AFFORDABLE "LOWER TIER" OF SERVICES OR PROVIDERS? OR A "HIGHER TIER"?

- This approach would perpetuate current "metal levels."
- Allowing a more affordable "lower tier" would be at odds with a goal of universal coverage
- If coverage is financed primarily by income taxes, affordability for the enrollee is no longer an issue.
- If State funding is insufficient for very generous coverage, a "base level" for all might be set, with an additional premium for more provider choice (as in the French system) or additional services.

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5. SHOULD INSURERS BE ALLOWED TO OFFER SIMILAR BENEFITS? OR ADDITIONAL BENEFITS?

- In the US currently, MediGap policies are permitted, subject to certain rules, to provide supplemental payments for hospital and other care for Medicare beneficiaries.
- Some nations (e.g. United Kingdom) allow commercial insurers to offer benefits that duplicate the state system, but provide better access to providers, and/or provide additional benefits.
- Other countries (e.g. Canada) explicitly ban such duplication, arguing that it undermines the state system.

6. WHAT CAN WE AFFORD?

- If coverage is financed primarily by income taxes, affordability for the enrollee is no longer an issue at the point of service. However, affordability for the State may be.
- To provide comprehensive benefits (as in the Washington Health Trust proposal) for non-Medicaid enrollees[1] would increase payments over and above what employers and employees are now paying by some $2 billion (based on HHS analysis of MEPS data), excluding any effects of administrative simplification or more effective price competition.

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[1] Also non-ERISA and non-Medicare

ROGER COLLIER rcollier@rockisland.com

Roger Collier was formerly CEO of a national health care consulting firm. His experience includes responsibility for managing the implementation of new state and federal health care programs for millions of enrollees.

ROGER COLLIER rcollier@rockisland.com

Submitted by Cris Currie
04/02/2024

To the FTAC and the UHCC:

In response to Bob Murray's comment at the March, 2024 FTAC meeting that Whole Washington was "overemphasizing" administrative costs in our current healthcare system, I would like to offer evidence to the contrary. We spend more on healthcare in the U.S. than any other country because our prices are much higher. Numerous studies over the last 40 years, including the PERI economic study, indicate that administrative waste followed by overpriced prescription drugs are the two largest contributors. Certainly the numbers and assumptions vary from study to study, but one recent literature review concluded there is a "high degree of consensus for the fiscal feasibility of the single-payer approach in the U.S."

Gerald Friedman estimated a $476 billion/year savings with administrative simplification, and Uwe Reinhardt, in Priced Out: The Economic and Ethical Costs of American Health Care, published just after he died, accepted a $765 billion/year estimate that included "unnecessary services, inefficiently delivered care, excess administrative costs, excessively high prices, missed prevention opportunities, and fraud." Most of this can be eliminated with a well designed single-payer system. Reinhardt said: "the issue of universal coverage is not a matter of economics. Little more than 1% of GDP assigned to health could cover all. It is a matter of soul."

The recent CBO working paper on healthcare costs also points to excessive administration as one of the two top drivers of high costs, but significant simplification cannot and will not happen until healthcare financing is completely restructured without private insurers. Determining exactly how universal healthcare will be funded in Washington should be the UHCC's top priority now. We can't just rely on transparency and price capping, important as they are as transitional steps. There is no point in wasting even more time on *talk* of administrative simplification as the UHCC work plan indicates. Rather, the UHCC must immediately commit its very limited energies to actual single-payer system design, using SB 5335 as the starting place. The legislator requested June report on SB 5335 should indicate this direction.

So those of us who have been involved with this movement for many years would strongly encourage all members of the UHCC and FTAC to read the studies and the bills that have been produced in other states. The answers to most of your questions are already out there, but you will need to study them on your own time, not in meetings. Please do not waste any more meeting time needed for decision making!

Core documents should include the Washington Health Securities Trust (WHST), the Washington Health Trust SB 5335, Friedman's Washington Study, WA UHC Work Group Report, Oregon Task Force Final Report, Oregon UHC Governance Board SB 1089, California AB 2200, ACA 11, and the Healthy California Commission Report, the Massachusetts Health Care Trust, the Medicare for All Act HR 3421, the SBUHCA HR 6270, the CALTCHA Model, and the Labor Campaign 10 Provisions.

Additional state proposals to review include: Minnesota Health Plan, Michigan MiCare Plan, New York Health Act, Ohio Health Care Plan, Vermont Green Mountain Care and Hsiao Report, Rhode Island Comprehensive Health Insurance Program, New Mexico Health Security Act, and the ColoradoCare Initiative.

Cris M. Currie

Tab 4

FTAC updates

Benefits & services

FTAC's March meeting

David DiGiuseppe, Alternate FTAC Liaison

- Review Benefits & Services approaches by
  - Whole Washington, Washington Health Trust (SB 5355)
  - Universal Health Care Work Group (predecessor to the Commission)
  - Other states
- Assess preliminary comparison of benefits across Medicaid, Essential Health Benefits (EHB) under the Affordable Care Act (ACA) and the Uniform Medical Plan (UMP) under the Public Employee Benefits Board (PEBB)/School Employee Benefits Board (SEBB) as an example of large group market
- Identify gaps in preliminary benefits comparison
- Develop considerations for the Commission for a path forward including an actuarial analysis

Whole Washington's presentation on SB 5335

David DiGiuseppe, Alternate FTAC Liaison

Like the states of California and Vermont, Whole Washington based the benefits and services for their proposed Trust on the ACA's EHB.

Financed via new taxes on employers, employees, capital gains, and sole proprietors.

The Trust would begin as Model B (state-designed plan privately administered) and would progressively transition to Model A (state-administered).

The Work Group's projected cost savings for Model A don't compare with SB 5335's projections for the same model.

Whole Washington's projected savings come mostly from reduced administrative waste by way of consolidating markets.

FTAC's concerns

David DiGiuseppe, Alternate FTAC Liaison

FTAC and Whole Washington largely agree on the goals for addressing fragmentation, inequitable access to care and coverage, and high costs. However, FTAC raised several concerns, including:

- Projected cost savings do not match other estimates.
- Assumes that
  - The proposed new tax structure is politically feasible and implemented
  - Federal regulations/barriers can be overcome, ERISA, Medicare, & Medicaid markets easily consolidated, and private industry (and associated administrative spending) is eliminated "at the pace that is possible"
  - Reduced administration = primary source of savings vs. price/market power.
  - Greatest cost savings is achieved once private industry (and the associated administrative spending) are eliminated, markets are consolidated, and a state-administered model is operational.

FTAC's concerns cont'd

David DiGiuseppe, Alternate FTAC Liaison

- Proposal does not address the issue of price. It would be very difficult and unsustainable for Washingtonians to bear the cost of a new health care system without first addressing costs and price in the current system.
- Unclear on details regarding an implementation plan, how federal barriers will be addressed, cost-containment mechanisms, discrepancies in projected savings.
- What is the feasibility of a single-payer system with the social, political, economic changes that are required, e.g., eliminating the private health insurance industry, development of waivers, raising taxes, etc.
  - Why not look at other OECD countries' social insurance systems with universal coverage that utilize regulated rate system to control costs/make health care more affordable?
- What is Whole Washington proposing that is not already being examined by FTAC/UHCC?

FTAC's assessment of benefits

David DiGiuseppe,
Alternate FTAC Liaison

SB 5335's proposed benefits are modeled after the EHB required by the ACA.

- General benefit design isn't the most pressing issue, e.g., Washington currently has a standard benefit design offered on the Exchange.
- Cost sharing is the biggest component of benefit design because it translates directly to the overall costs of the health care system.
- Necessary to bring down the total cost of care to bring down the costs of the new health care system.

Commission questions and discussion

Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting summary

March 14, 2024
Virtual meeting held electronically (Zoom)
2–4:30 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **FTAC webpage**.

Members present

David DiGiuseppe
Eddy Rauser
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Christine Eibner
Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

Pam MacEwan began with a land acknowledgement, welcomed members to the eighth meeting, and reviewed the agenda.

Meeting summary review from the previous meeting

The Members present **voted by consensus to adopt the January 2024 meeting summary**.

Public comment

Roger Collier suggested that there were some discrepancies in the savings projected under the Washington Health Trust on pages 19-20 under Tab 5 of the meeting materials.

Marcia Stedman, Health Care for All Washington, expressed support for the two primary agenda topics and the extra time dedicated for robust committee discussion.

Consuelo Echeverria noted that additional time allotted for meetings is thanks to advocates' efforts and stressed the importance of completing the required report of the Universal Health Care Commission (the Commission) due to the Legislature on June 30.

Kathryn Lewandowsky read an email from Dr. Friedman (author of the economic analyses supporting Whole Washington's SB 5335) who expressed regret for being unable to attend the meeting due to health issues.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

The Commission directed FTAC to provide guidance on benefits and services for Washington's future universal health care system. The Commission plans to have an actuarial analysis conducted to compare benefits across Medicaid, the essential health benefits (EHB) mandated under the Affordable Care Act (ACA), and the Uniform Medical Plan (UMP) under the Public Employee Benefits Board (PEBB). Today's meeting is focused on understanding what work in this area has already been done, identifying any gaps and additional considerations for designing a benefits package.

Presentation: The Washington Health Trust – Benefits & Services

Andre Stackhouse, Whole Washington

Whole Washington, proponents of Senate Bill 5335 (SB 5335), presented on the benefits and services and financing under their proposed Washington Health Trust (Trust). This is part of the Commission's directive by the Legislature to examine SB 5335.

Professor Gerald Friedman, author of the Trust's economic analyses, anticipates health care costs doubling in the next ten years. Increased health care costs have not resulted in increased life expectancy or increased access to care. The U.S.'s total health care spending is twice that of the Organization for Economic Co-operation and Development (OECD) average without achieving universal coverage.

The Universal Health Care Work Group (Work Group) and Dr. Friedman used different methodologies to project health care costs under the status quo. The greatest cost reductions would be realized under a publicly funded and publicly administered health care system (Model A as proposed by the Work Group). The Trust would begin as Model B (state-designed plan privately administered) and would transition to Model A.

Covered benefits and services are modeled after the EHB mandated under the ACA. Revenue sources to support the proposed Trust include an employer payroll tax, an employee payroll tax (employer may choose to cover employee portion), a sole proprietorship tax, and a capital gains tax (ruled by the 2023 Washington State Supreme Court as constitutional exempting the first $250,000). This would be less burdensome on individuals, families, and employers compared to the status quo.

FTAC members were invited to make comments/ask questions. It was noted that other OECD countries with social insurance systems manage cost and price growth through rate setting systems for all providers (the U.S. does this for public coverage but not for private), which may be more economically and politically feasible. Whole Washington noted the Commission's position to make recommendations without political influence could aid in the political feasibility of either the Trust proposal or an alternative. Additionally, the Trust would incorporate rate setting and may be more politically feasible given the transition period from Model B to Model A.

Members noted that the disparity in health care expenditures in U.S. versus OECD countries is largely due to prices, however Dr. Friedman's analysis names health care administration as the primary source of savings with prices being secondary. Whole Washington welcomed additional cost analysis methodologies and financing model alternatives. Committee members noted that having broader participation and consensus on a cost

analysis will lend credibility to the discussion. Whole Washington agreed that private health carriers are not the sole contributor to higher health care costs in the U.S., nor are they the only opposition to universal health care, e.g., hospitals. Members noted that consolidation drives price increases which drives spending, and taking a broader approach and not focusing only on simplifying health care administration should be the focus of regulatory action.

Whole Washington expressed that while there are challenges with SB 5335, they'd like to hear more reform proposals and solutions from the Committee/Commission. FTAC and Whole Washington agree on the goals for addressing fragmentation, high costs, and inequitable access to care and coverage. It was noted that other OECD countries do not face housing or food insecurity, barriers to education, income inequality, etc., as so many Americans do. These factors, beyond just access to universal health care, are major determinants of health.

There will be more opportunities to reconnect with Whole Washington to further assess SB 5355 as part of the Commission's legislative directive.

Benefits & Services Discussion

In prior meetings, FTAC has outlined the challenges to integrating Medicare and self-insured group health plans (large employers) into Washington's universal health care system. However, there are paths forward for integrating Medicaid, the individual market, and small and large fully insured group health plans.

A grid comparing covered benefits across Medicaid, EHB, and UMP does not exist. However, other states proposing universal health care plans have conducted benefits modeling and chosen EHB (California and Vermont) or the public employee benefits plan (Oregon). Creating a comparison grid of benefits is challenging. Medicaid has benefits that are required by the Centers for Medicare and Medicaid Services (CMS) to obtain federal matching dollars, and fully insured market plans must provide state-mandated benefits not required in the EHB. Members noted that it may be helpful to know how many of the Medicaid unique benefits are related to pediatrics, maternity care, and children with special health care needs.

Wakely's recent comparison of PEBB and Washington's EHB and found PEBB to be approximately 0.24 percent to 0.54 percent more generous (on an allowed cost basis). However, Medicaid is the most generous benefit plan.

There will be a high degree of overlap between Medicaid (keeping Long Term Services and Supports [LTSS] off the table), and general benefit design may not have much impact on the total cost of care, so the issues of interest will be around duration, scope, and cost-sharing. It's important to consider that the benefits for Medicaid, PEBB, and EHB are somewhat tailored to the needs of the respective population demographics, e.g., PEBB - working adults and families, the Exchange - primarily adults, and Medicaid - originally intended for mothers and children.

Benefit generosity between PEBB and EHB is almost negligible from a per-member per-month (PMPM) perspective. It may be helpful to model the most practical benefits package (most socially and politically feasible) and incrementally model out additional benefits, potentially introducing some cost-sharing.

FTAC pondered whether the barriers are too high to make single payer work. There was agreement that it's crucial to address price head on because it is not possible to create a more equitable, accessible, affordable health care system without doing so. Price regulation may be more politically possible than taking on providers, carriers, and the federal government. For example, Oregon recently passed price caps (200 percent of Medicare) on their PEBB/Oregon Educators Benefit Board (OEBB) plans and with evidence of significant savings, Washington should consider pursuing the same. Consolidating and expanding state purchasing is another avenue. Washington did have a hospital commission modeled after Maryland's but failed in implementation.

FTAC agreed that the Commission should consider the following for an actuarial analysis: Begin with PEBB or EHB and layer on additional benefits to be modeled. Cascade Care (standard qualified health plans on the Exchange) could serve as the starting point for EHB to see the cost-sharing impact on premiums across the Bronze, Silver, and Gold metal levels, and then assess whether Medicaid and PEBB cover anything different. Members requested that "PEBB" be updated to "PEBB/School Employee Benefits Board (SEBB)." Other

dimensions of benefit design should be considered in future meetings, including prior authorization, supplemental benefits outside of the universal plan's covered benefits, point of service cost sharing, and a standardized provider reimbursement rate.

Adjournment

Meeting adjourned at 4:32 p.m.

Next meeting

May 9, 2024
Meeting to be held on Zoom
2–4:30 p.m.

Tab 5

State agency report outs

2024 Legislative session recap

Evan Klein, Special Assistant
Legislative and Policy Affairs

Washington State Health Care Authority

2024 Legislative priorities

- Ensuring and expanding access
- Behavioral health investments
- Medicaid Transformation Project (MTP) renewal
- Investing in clinical quality
- Advancing equity
- Enhancing maternal services
- Rates, benefits, and operations

2ESSB 1508

- Adjusts the structure of the Health Care Cost Transparency Board's (Cost Board) stakeholder advisory committee and directs new work of the Cost Board.
- New requirements:
  - Public hearing for entities subject to benchmark
  - Underinsurance Survey
  - Survey of Insurance Trends

Coverage policy

- **E2SSB 5213** – Modifies and strengthens regulatory requirements for pharmacy benefit managers (PBMs), including those PBMs utilized by our state-purchased programs.
- **SHB 1979** – Requires health plans (including PEBB/SEBB) to cap the out-of-pocket cost of 30-day supply of inhalers and epinephrine autoinjectors at $35 starting January 1, 2025.
- **SSB 5986** – Protects consumers from out-of-network health care services charges.
- **ESHB 1957** – Preserves coverage of preventive services without cost sharing.

Failed bills

- **ESB 5241 (Keep Our Care Act) –** Concerning material changes to the operations and governance structure of participants in the health care marketplace.
- **HB 2476 –**Establishing a covered-lives assessment for purposes of increasing professional services rates in the Medicaid program to Medicare levels.
- **HB 2066** – Addressing affordability through health care provider contracting.

Expansion and consolidation of coverage

- **Apple Health Expansion (immigrant health coverage) investments**
  - Coverage begins July 1, 2024
- **PEBB/SEBB**
  - Program staff resources
  - Study consolidation
- **Essential Health Workers**
  - Establish coverage program for essential health workers & explore options for expansion

IT investments

- **Community Information Exchange (CIE)**
  - Examine existing platforms, interoperability, and fiscal impacts.
  - Will serve as a tool for addressing social determinants of health.
- **Electronic Health Records (EHR)**
  - EHR interagency agreement with HCA who is, and will be, the reporting entity to the federal government on the application for and use of the federal funding.
- **Integrated Eligibility & Enrollment (IE&E)**
  - Continuation of efforts to design and implement a benefits access portal for clients across multiple U.S. Department of Health & Human Services (HHS) agencies.

Rate increases

- **Tribal Encounter Rates**
  - HCA to implement tribal encounter rates as part of the new pharmacy point-of-sale system.
- **Non-Emergency Medical Transportation (NEMT)**
  - Increase the NEMT broker admin rates.
- **Inpatient Per Diem Rates**
  - Increase inpatient per diem rates for inpatient Prospective Payment System hospitals by July 1, 2024.
- **Private Duty Nurses**
  - Increase rates for private duty nursing, home health, and medically intensive children's group home program services.
- **Substance Using Pregnant People (SUPP) Program Rates Review**
  - Review rates for SUPP Program to determine if a rebasing is appropriate and submit a budget request if necessary.

Looking ahead

- Apple Health Expansion (July 1)
- Cost Board updated analyses
- PEBB/SEBB consolidation study
- Electronic Health Records (EHR)
- Reentry & MTP 2.0

Questions?

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Washington State Health Care Authority

Break

Tab 6

Administrative Simplification – A Local Perspective from Richard Rubin, The Washington Healthcare Forum Administrative Simplification Program

1. Background
2. Challenges
3. Opportunities

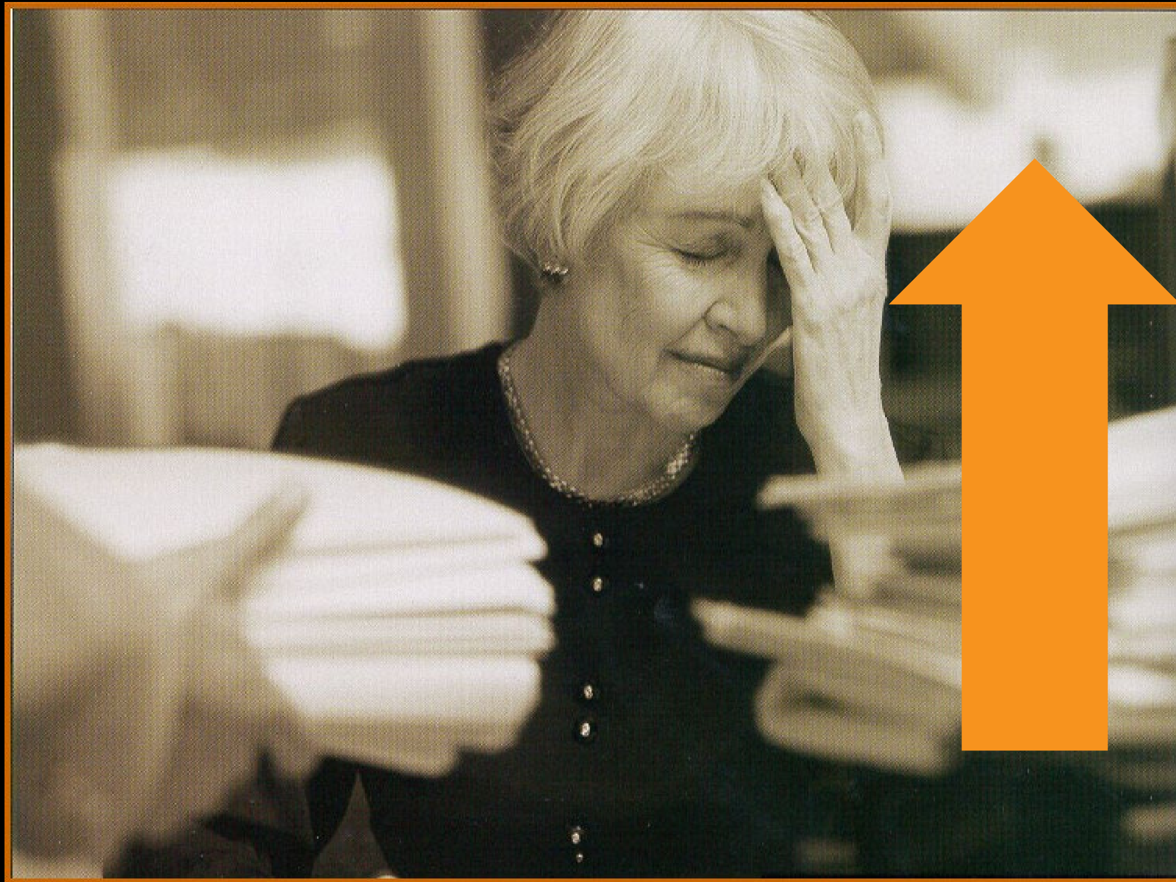
The Washington Healthcare Forum Admin Simp Program:

Making it Easier for Healthcare Organizations to do Business Together

The Lead Organization – private operation with public oversight – "run it like a business, but in the public interest"

The Community View –
“Looking In”

Overall Complexity is Increasing



Local Span of Control is Limited

Challenging to Move from Policy to Implementation

It is unlikely simplification efforts will translate into hard dollar savings for the health system – But there are other benefits that still make it worthwhile

Local Targets of Opportunity

The Terrible Too(s) of Collaboration

Too early

Too late

Too small to matter

Too big to be true

Some Market Momentum
Can leverage existing investments
Local Targets of Opportunity
Feasible wins within reach
Meaningful action can be taken at state Level

Local Opportunities

Expert stakeholder review

Pre-service

Consumer engagement

Performance measurement

SDOH/enhanced demographics

Behavioral health

Expert Stakeholder Review

Use Subject Matter Expert workgroup to prospectively review legislation and/or policy recommendations that impact health services administration

Pre-Service

Pre-authorization is only one of many checks providers need to make prior to service in order to be assured of claims payment

Admin Simp has a Pre-Service work group that works on the larger question – how can we move beyond reliance on traditional methods (transactions, fax, phone calls, etc.) to something better?

Consumer Engagement

Putting “patients in the center” and “meeting people where they are” are widely held aspirational goals – also state and federal laws require “simplified” consumer access to their health information

How could we accelerate consumer mediated exchange?

Performance Measurement

Performance measurement is a key component of value-based strategies – NCQA is moving to digital methods, CMS is moving to consolidate quality measurements, WA State has a Performance Measurement Coordinating Committee and local expert organizations

What would it look like to lead innovation of performance measurement?

SDOH/Enhanced Demographics

Broad agreement that improving health means addressing determinants of health and inequities – this will require measurement

National standards work being done in this area, local efforts on best practices and implementation

How can we adopt best practices from the get-go and avoid building silos and deploying incompatible proprietary approaches as we enter this new space?

Behavioral Health

Significant work underway to integrate physical/behavioral health – yet, important differences remain in administrative approaches – and state government is a major player in this space

How can we enhance and accelerate clinical integration by better coordinating the administrative elements of physical and behavioral health?

Washington Healthcare Forum Admin Simp Program
Catalogue of Major Administrative Simplification Initiatives

Year	Initiative	Type	Area	
2001 - 2008	Developed Policies, Guidelines and an Adoption Matrix for: • Claims Processing (14) • Credentialling (3) • Electronic Exchange of Information (2) • Referral & Prospective Review (8). Developed an on-line, interactive table to display requirements by health plan	Workgroup	Operations	
2001- 2024	Developed Best Practice Recommendations for implementing and updating 8 HIPAA transactions – for versions 4010, 5010, 8020. Ongoing consultation with OIC to recommend how implementation and regulations can best be aligned. Participated WEDI, CAQH Core & X12 to influence direction	Workgroup	Technology	
2007 - 2009	Developed operational work flow best practice recommendation for estimating and collecting patient payments within provider organizations	Work Group	Operations	
2008	Developed a report to the Governor and Legislators on the top five health care administrative simplification goals, and a plan to achieve those goals	White Paper	Policy	
2009	Incorporated SB5346 requirements into HIPAA transaction BPRs	Workgroup	Technology	
2009	Developed an assessment and recommendation for the Task Force on Insurance Simplification—About Changes Needed To Reduce Administrative Costs	White Paper	Operations	

2009	Developed recommendations to the OIC for rules changes to WAC 284-51-215 Coordination of Benefits	White Paper	Technology / Operations	
2009	Developed finding and recommendations for the OIC to protect provider organizations and health plans from the impact of retroactive denial of eligibility	White Paper	Policy	
2009-2010	Developed 2 best practice recommendations for implementing SB5346 legislation re: claim coding policy and edits	Workgroup	Claims Coding	
2009-2024	Developed 3 best practice recommendations for implementing SB5346 legislation re: medical pre-authorization	Workgroup	Pre-Service	
2010-2017	Sponsored and facilitated annual Administrative Simplification Workshops across the state	Presentation		
2010	Assessed implementation approach for SB6273 (sales tax on DME items) for Department of Revenue	Analysis Paper	Technology	
2010	Developed an assessment of HR3590 (HIPAA) sections 1104 and 10109 and how those sections may impact Administrative Simplification efforts in Washington State	Analysis Paper	Technology / Operations	
2010	Facilitated a structured process to propose a set of goals and work plan for the development of medical management protocols.	White Paper	Policy	
2010 - 2011	Facilitated collaboration to understand and share information about how payers were implementing ICD-10 and to assess provider readiness	Workgroup	ICD10	
2011	Requested the Office of Insurance Commissioner (OIC) to initiate rule-making to amend the 'Pay to the Higher Allowed' Provision of WAC 284-51-195	White Paper	Policy	
2011-2014	Developed methodology and validated health plan implementation of pre-authorization best practice recommendations	Validation	Operations	

2013-2016	Developed methodology and validated health plan implementation of HIPAA transactions	Validation	Technology	
2014	Provided feedback to Office of the Governor on draft legislation Z-0692.1/14 – vision of an improved model of healthcare purchasing and delivery.	White Paper	Public Policy	
2014-2015	Developed 3 best practice recommendations for implementing SB5346 legislation re: pharmacy pre-authorization	Workgroup	Pharmacy	
2015	Developed best practices for implementing SB5557 legislation – billing and reimbursement for expanded role of pharmacists	Workgroup	Pharmacy	
2016	Assessed implementation approach for RCW – Takeback Handling - for OIC	Analysis Paper	Technology	
2016	Developed findings, assessment and recommendations related to Goldcarding	White Paper	Policy	
2020	Facilitated collaboration to track and understand delivery system adaptations to the coronavirus crisis and consider if/how the payment system may be able to respond. Published ongoing updates about carrier changes	Workgroup	COVID	
2021	Drafted "From Attachments to Clinical Information Exchange" to understand the problem and the likely solution pathway	White Paper	Technology	
2021 - 2022	Developed a vision, rationale and requirements definition for a Provider Data Hub (HUB)	White Paper	Operations	
2021-2022	Developed recommendations to the OIC for how the implementation of the Eligibility & Benefits transaction could be aligned with state requirements for the Balance Billing Protection Act	Analysis Paper	Technology	
2022	Prepare an RFI response to the Office of the National Coordinator (ONC) about how best electronic technology can be used to simplify the pre-authorization process.	White Paper	Technology	

2022-2024	Developed Consensus Recommendation & Issues resolution for implementation of Behavioral Health HB1688 – Commercial Coverage for Behavioral Health Services	Workgroup	Behavioral Health	
2023 - 2024	Drafted synopsis of 1) the Federal proposed rule and final rule for Advancing Interoperability and Improving Prior Authorization Processes, 2) A comparison of those rules and HB1357	Analysis Paper	Technology	
2023 - 2024	Developed a plan for transitioning state-wide credentialling from Medversant to CAQH	Workgroup	Operations	
2023-2024	Developed a comparative assessment of Federal final Interoperability and Pre-Auth Rule (proposed and then final) and SB1357	Analysis Paper	Technology / Operations	

Tab 7

Next steps

- Begin work to conduct actuarial analysis

- Whole Washington report to the Legislature
  - UHCC review of draft report
    - Draft located under Tab 8 of today's meeting materials
    - Draft includes feedback from Whole Washington and their partners
  - UHCC feedback due to HCA on Tuesday, April 30
  - UHCC's feedback will be incorporated, and report will undergo HCA Communications review
  - UHCC will vote to adopt report at June meeting
  - HCA submits to Legislature on behalf of UHCC by June 30 due date

- FTAC continues Benefits & Services discussions

Washington State Health Care Authority

Thank you for attending the Universal Health Care Commission meeting!

Tab 8

Universal Health Care Commission

Washington Health Trust (SB 5335) analysis report

Legislative report

June 30, 2024

DRAFT

Washington Health Trust analysis report

Acknowledgements

The Universal Health Care Commission (Commission) would like to thank the leaders and members of Whole Washington for their collaboration and important contributions to this report. Whole Washington is a grassroots coalition that supports both state and national efforts working to make Universal Healthcare a reality. This report is being submitted in response to the legislative request for an assessment of the Washington Health Trust proposal's alignment with the goals and planned activities of the Commission, and whether and how the Commission might recommend implementing the proposal if considered within the Commission's mission and a viable proposal. Elements of the Washington Health Trust proposal not captured in this report will continue to be assessed in collaboration with Whole Washington and will be included in the Commission's annual report beginning in 2025 until the analysis is complete.

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Executive summary

In 2023, the Commission received a request from members of the Legislature to assess whether and how the Commission might recommend implementing the Washington Health Trust (**SB 5335**) proposal as introduced in the 2023 legislative session, if the Commission considers it within their mission and a viable proposal. SB 5335 proposes the creation of the Washington Health Trust within the Washington Department of Health to provide coverage for a set of essential health benefits (EHB) to all Washington residents.

In response to this request, the Commission voted to incorporate the assessment of SB 5335 into the Commission's work plan to the extent possible within the requested timeframe and available resources. At this time, it is not possible to recommend whether and how the Trust might be implemented because the Commission is still early in its universal health care system design work and a complete assessment of a proposed universal health care system will take time and careful consideration. Additionally, there are outstanding questions regarding the SB 5335 proposal that will need to be answered to determine whether it is a viable proposal and how it would be implemented.

However, the Commission did examine areas of alignment between their work to date and SB 5335. Whole Washington accepted invitations to present to both the Commission and their subcommittee on finance (the Financial Technical Advisory Committee also referred to as FTAC) across several meetings. [1 & 2 & 3] Specifically, this report includes an assessment of whether elements of the proposal align with the goals and planned activities of the Commission, including

- Eligibility
- Enrollment
- Benefits & Services

Beginning in 2025, and until the analysis is complete, each of the Commission's legislative reports will summarize SB 5335 and how it would address key design components of a universal health care system. The Commission will continue to engage with Whole Washington members throughout the analysis and report development process.

How to read this report

This report aims to identify areas of alignment between the Commission and SB 5335 on larger health care system design. The report contains summaries of key considerations and decision points by the Commission and proposals in SB 5335, followed by an alignment table for each design element. Each alignment table illustrates areas of alignment and/or the degree of the alignment between the Commission and SB 5335 for each design element. Areas of alignment may change over the course of the Commisison's deliberations. For purposes of reading the alignment tables:

- Green signifies full alignment between the Commission and SB 5335
- Yellow signifies some areas of alignment between the Commission and SB 5335
- Red signifies no alignment between the Commission and SB 5335

[1] Commission's **August 2023 meeting recording**.
[2] Commission's **December 2023 meeting recording**.
[3] Finance Technical Advisory Committee **March 2024 meeting recording**.

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- Gray signifies that determining alingment bears further analysis and is not possible at this time.

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Background

The Commission's charge

As directed by the Legislature, the Commission must:

> "Implement immediate and impactful changes in the state's current health care system to increase access to quality, affordable health care by streamlining access to coverage, reducing fragmentation of health care financing across multiple public and private health insurance entities, reducing unnecessary administrative costs, reducing health disparities, and establishing mechanisms to expeditiously link residents with their chosen providers; and
>
> establish the preliminary infrastructure to create a universal health system, including a unified financing system, that controls health care spending so that the system is affordable to the state, employers, and individuals once the necessary federal authorities have been realized. The Legislature further intends that the state, in collaboration with all communities, health plans, and providers, should take steps to improve health outcomes for all residents of the state."

Washington has long been a leader of health care reform in the U.S., however gaps in coverage, health equity, affordability, and access to culturally competent, high quality care persist for too many Washingtonians. The Commission remains committed to finding ways to achieve the greatest and most immediate impact for the greatest number of people. With this goal in mind, and focusing partly on interim steps and partly on future system design, the Commission has focused its work on the following areas:

- The **baseline report** (2022) to the Legislature and subsequent **annual report** (2023)
- Determining eligibility for the future universal health care system
- Preliminary discussions on benefits and services for the future universal health care system
- Identifying ways to improve the current health care system that will also support the state's transition to a universal health care system
- Adoption of a health equity framework with which to evaluate proposals for the new system design
- The request to analyze the Washington Health Trust (Trust) bill.

As requested by members of the Legislature, this report will focus on areas of alignment between the Commission and SB 5335. As time and resources have allowed, the areas of alignment outlined in this report include larger system design elements including eligibility and benefits and services. Interim strategies and other design elements will be included in the Commission's annual reports to the Legislature beginnning in 2025.

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Eligibility and enrollment

Background

Achieving universal coverage requires determination of how to design a system through which all Washington residents would be eligible for coverage. The Legislature's goal is to include all state residents in Washington's future universal health care system. As such, the Commission selected eligibility as the first design component to examine.[4]

The three programs which cover the greatest number of Washingtonians include Medicare, self-funded employers, and Medicaid. Fully integrating enrollees of these programs in the universal system, both in terms of administration and financing, is important to achieving administrative simplicity and savings that would come with a universal health care system. However, each presents significant barriers with respect to the ability to include their enrollees in Washington's universal system. These barriers are largely due to provisions of federal law and regulation. For example, Medicare is an entirely federal domain both in terms of funding and administration. Conversely, while Medicaid is administered and partly funded by states, the program also receives federal funding and federal law establishes certain eligibility criteria. Finally, federal law preempts state regulation of self-funded employer health benefit plans.

In their eligibility discussions, the Commission has identified potential pathways for enrollees of these programs, particularly Medicare[5] and self-funded employer plan enrollees, to receive the same benefits as those offered under the universal system while maintaining separate administration of those programs. Ultimately, the long-term goal for both the Legislature and the Commission is to ensure eligibility for all Washington residents, including enrollees of these respective programs when possible.

Medicare

Medicare is a federal health insurance program for individuals aged 65 and older. Individuals under 65 with long-term disabilities also qualify for Medicare through the Social Security Disability Insurance (SSDI). Approximately 1.4 million Washingtonians are enrolled in Medicare.[6]

[4] In their **baseline report**, the Commission identified the following design components of a universal health care system: cost containment, coverage and benefits, eligibility, enrollment, financing, governance, infrastructure, and provider participation and reimbursement.

[5] This is especially true of Medicare, both because it is unlikely that Congress would turn the program over to states and also because of the budgetary burden it would place on states.

[6] Monthly enrollment by state. Washington. March 2023. CMS. **https://www.cms.gov/research-statisticsdata-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollmentstate-2023-03**

Commission

The Commission consulted with their Finance Technical Advisory Committee (FTAC)[7] on options to address potential gaps in benefits and out-of-pocket costs for Medicare enrollees in Washington's future universal health care system. Six options[8] were evaluated along with the pros and cons of each.[9]

Of the six options, establishing a system to directly reimburse Medicare enrollees for cost-sharing and for services covered by the universal system but not by Medicare would be the most expedient for the state to implement. For example, this option allows the most flexibility to fully address gaps and would not require waivers nor result in delays due to legal challenges. This option could also be explored in conjunction with a waiver as a tool for cost containment.

However, disadvantages to this option include the potential variances between Medicare enrollee choices, with federal rules potentially limiting the ability to wrap around Medicare Parts A[10] & B[11]. This option could also invite gaming from Medicare Advantage (MA) plans and may be administratively burdensome for the state and consumers. Finally, this option does not allow the state to leverage federal Medicare dollars.

A waiver[12] is the ideal approach to both integrating Medicare dollars and addressing coverage and affordability gaps for Medicare enrollees in the universal system. However, currently, pursuit of such a waiver is not an effective use of resources or time due to legal uncertainty over whether action by Congress would be needed. Additionally, the Centers for Medicare and Medicaid Services (CMS) is unlikely to grant a waiver to a new and untested program, even if it is determined that it has the authority to do so.[13]

Direct reimbursement, which could be explored in conjunction with a waiver, is the most feasible option for the short term to achieve policy goals. This option will be revisited with further analysis to determine what gaps need to be filled between existing Medicare services and that of the new system once more system design elements have been determined by the Commission.

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[7] **FTAC roster**.

[8] Evaluated options include an act of Congress, demonstration waiver, a Medicare Advantage (MA) plan as the only option for Medicare enrollees, an MA plan designed by the state that competes with other MA plans on the market, a state-designed and offered Medigap plan, and direct reimbursement.

[9] The Commission's full eligibility assessment for Medicare-eligible Washingtonians can be found in Appendix A.

[10] Inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

[11] Preventative services, outpatient care, certain doctors' services, and medical supplies.

[12] If obtained, a comprehensive waiver granted by CMS would allow Washington to enroll all Medicare enrollees into the universal system design and leverage federal funding, a key advantage of this option. However, FTAC identified that there is no legal precedent for such, and it is unlikely to be achieved via legislation through the current Congress.

[13] In their environmental analysis to the governor and state legislature, the Healthy California for All Commission (HCAC), also charged with developing a state-based universal health care system, identified limitations with CMS' waiver authority, stating "it does not appear that CMS' waiver authority is broad enough to allow even a cooperative federal administration to flexibly fund the Medicare portion of a California system of unified financing without statutory change.

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SB 5335

Under SB 5335, Medicare enrollees would be eligible to enroll in health care coverage under the Washington Health Trust (Trust).[14] SB 5335 recognizes that in the long term, integration of federal Medicare dollars would be essential to supporting and sustaining the Trust. To address gaps in coverage and cost-sharing for Medicare-eligible Washingtonians in the interim, SB 5355 proposes the creation of a state funded and managed Medicare Advantage – Part D (MA-PD) plan. The MA plan under the Trust would compete with private MA plans and traditional Medicare and be available to Medicare enrollees who elect the Trust coverage as their MA plan.[15 & 16]

A state designed and administered MA-PD was also assessed by the Commission. For the state, this option would involve designing and implementing a MA-PD plan for Washington's Medicare enrollees that, to the extent MA rules allow, would provide benefits parity with Washington's universal system. This option does not limit Medicare enrollees' choice because Medicare-eligible Washingtonians would be able to enroll in the state's MA plan, a private MA plan, or in traditional Medicare. Making this option voluntary could potentially mitigate the threat of legal challenges that may arise if Medicare enrollees were forced to enroll in the state's MA plan.

In the Commission's assessment, there are some limitations with this option. For example, payment structures would need to be resolved, as MA payments are tied to Medicare's fee-for-service (FFS) benchmark compared with whatever payment structure is utilized in the universal system.[17] Another limiation of this option is the administrative costs the state would incur to develop, implement, and oversee an MA plan, or to contract to do the same. The main concern with this option is the competition the state would face by entering a mature MA-PD market in Washington with multiple carriers offering over 100 MA plans and that these plans are portable outside of the state of Washignton.[18] Additionally, Medicare enrollees may be inclined to renew existing coverage or could select options other than the state's, limiting the potential of federal dollars and the overall impact of this option.

However, the Commission did not recommend this option being completely removed as a possibility for including Medicare enrollees in a future universal health care system. There may be a possibility in the future for this option to sit alongside direct reimbursement to address gaps and this requires further assessment.

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[14] Proposed enrollment and eligiblity components of SB 5335 are outlined in its Sec. 111. All

[15] The bill is silent on what entity would be charged with designing and implementing the MA-PD plan, though it is intended as state funded and managed.

[16] Medicare enrollees with household incomes below 200 percent of the federal poverty level (FPL) who chose to enroll in the Trust would be reimbursed for Medicare premiums until federal Medicare dollars could be integrated to support the Trust. Design and implementation of reimbursement mechanisms would be at the discretion of the Washington Health Trust Board of Trustees established in Sec. 104.

[17] The Commission is scheduled to begin discussions on provider reimbursement in 2024, though this is subject to change pending progress made on other scheduled design elements throughout the year.

[18] Portability of health care plans across states may be very attractive to some Medicare enrollees, who would not select a state-based health plan.

Alignment between the Commission and SB 5335 for Medicare enrollees

The Commisison and SB 5335 are aligned in the goal of providing access to coverage and care for Medicare-eligible Washingtonionas under a state-based universal health care system. However, the means by which this goal is achieved in the interim may differ, at least in the Commisison's preliminary eligiblity deliberations.

It is not yet possible to determine whether the Commission and SB 5335 are aligned on intermediate strategies. The Commission plans to conduct further analysis once more design components of the universal system are determined, such as benefits and services. It will be especially important to assess any unintended consequences, potential legal challenges, health equity impacts, and costs and/or savings to the state.

The Commission and SB 5335 do align on the long-term goal to secure a waiver to integrate federal Medicare dollars. Additionally, SB 5335 gives discretion to the Health Care Authority (HCA) to develop a federal waiver to integrate Medicare funds. Details on the proposed waiver development process are outlined in Sec. 113 of SB 5335.[19]

Table 1 below outlines areas of alignment between the Commission's preliminary eligibility work and SB 5335. Green represents alignment and gray signifies that determining alingment requires further analysis.

Table 1: Medicare eligibilty areas of alignment

	Commission	SB 5335
Goal	Medicare enrollees are eligible for coverage and care under Washington's universal health care system[20] and federal Medicare funds can be accessed to support a unified financing system.	
Transition[21]	Directly reimburse Medicare enrollees for cost-sharing and services covered by the universal system but not by Medicare.[22] This option could be explored in conjunction with a waiver in the short term to achieve policy goals.	Supplement Medicare with a publicly funded and managed Medicare Advantage & Part D (MA-PD) plan that would compete with other private MA plans and traditional Medicare.
Long term	A federal waiver is the ideal approach to both integrating Medicare dollars and addressing coverage and affordability gaps for Medicare enrollees in the universal system. Securing such a waiver will take significant resources and time. Additionally, to be	

[19] Directives to HCA are outlined in SB 5335 under Sec. 113.
[20] SB 5399 stipulates that all residents would be eligible for coverage and access to care through a unified financing system once the necessary federal authority has become available.
[21] In the Commission's preliminary assessment, direct reimbursement surfaced as the most feasible option to include Medicare enrollees in a state-based universal health care system. However, this could be explored in conjunction with a waiver to contain costs. Additionally, the Commission did not remove for consideration a state-designed and operated MA-PD plan, though this requires further analysis.
[22] More details will be developed once benefits and services and other design components are determined.

	successful, the federal government may require the program to be tested and operational before considering granting a waiver.

Employers

Employers serve as a major source of health care coverage for Washingtonians. This makes integration of employers especially important both for making the new system universal and for the financial viability of Washington's unified financing system.

Commission

Washington can regulate employers with fully insured individual and group health plans. However, the Employee Retirement Income Security Act of 1974 (ERISA), a federal statute, preempts state regulation of self-funded employer health benefit plans,[23] or insurance plans where an employer covers the full financial risk of its employees' claims for health care benefits. Per the ERISA statute, regulation of ERISA plans is "exclusively a federal concern" and preempts "all state laws insofar as they…relate to any employee benefit plan," constraining Washington's ability to regulate employer benefits or achieve benefits parity between employer benefits and the future system. Pathways for capturing revenue, such as employer contributions, to support the unified financing system must be thoroughly examined.[24]

Unlike the waiver authorities granted to CMS under Medicare and Medicaid, there is no such authority in the ERISA statute. Legal challenges may be inevitable, and this requires further analysis. However, the Commission is taking into consideration experiences from other states. For instance, the Ninth Circuit Court of Appeals has upheld the establishment by the cities of San Francisco and Seattle of respective public-program alternatives, finding that they preserved employers' benefit choices sufficiently to avoid ERISA preemption. As demonstrated by both cities, providing employers a meaningful alternative to providing their own coverage, such as a new universal plan, would allow employers to choose whether to opt in and may therefore survive an ERISA challenge. This could eventually attract employers, or even serve as a glide-path to a single-payer system.

The Commission has also discussed the legal benefits of making participation in the new system voluntary for employers subject to ERISA. However, this would make funding for the new system less secure and less predictable.

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[23] Federal ERISA law sets minimum standards for health plans established and funded by employers to provide health care to their employees. Employer health plans can be "fully insured" or "self-funded". Both types of these health plans must comply with ERISA. However, the state's role varies based upon whether a plan is fully insured or self-funded. An employer that offers a fully insured health plan is paying for premiums to a health insurer and the insurer bears the financial risk of coverage. An employer that offers a self-funded health plan has chosen to bear the financial risk of health care services used by their employees, and often will contract with an outside entity to administer their health plan (called "third party administrators" or "TPAs"). The ERISA statute exempts these plans from most state regulations.

[24] The Commission's full eligibility assessment for individuals receiving health care coverage through self-funded employer plans can be found in Appendix B.

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Provider regulation and/or incentives must also be considered as a part of the design of the universal system, not only to achieve universality in principle, but also to provide the state with levers to achieve a unified financing system in practice. However, requiring providers to contract with the universal plan without the ability to contract with other plans may be preempted by ERISA. Further analysis and discussion will be needed to expand upon this option to understand specific policy requirements, political hurdles, and cost impacts.

A mechanism to capture revenue from large employers will also be critical. However, it's important to consider the inverse relationship between the financial security a funding mechanism may provide and the potential risk to the state that mechanism runs in terms of running afoul of ERISA. For example, a payroll tax on all employers regardless of whether they continue to offer employees health care coverage may provide a more reliable stream of revenue, but may also make the state vulnerable to, and unlikely to win, an ERISA challenge. A funding mechanism, in combination with some or all the above policy levers, will need to be examined with the assumption that there will be an ERISA challenge(s). This requires further analysis. The Commission plans to further discuss the best strategy to give the state a stronger footing in the likely event of an ERISA challenge.

Finally, large employers are likely to fiercely defend ERISA, and their perspectives on state-based universal health care and buy-in will need to be carefully considered. Continuing to engage large employers will also be important to identifying opportunities to make a universal system more appealing or acceptable, including administrative simplicity, better cost control, and optional participation in the universal health care system. More specific policy levers to integrate employers into the universal health care system will be revisited once more design elements of the larger system are determined.

SB 5335

SB 5335 recognizes the barriers brought by ERISA preemption of large employer health plans. SB 5335's approach to include employees and integrate employer funding to support the Trust is modeled after Healthy San Fransisco,[25] a public-program alternative that preserved employers' benefit choices enough to avoid ERISA preemption. Employers would have the option to either maintain existing employee benefits plans or to allow employees to enroll in coverage under the Trust.

However, employers would be required to pay a minimum percentage of each employee's payroll toward that employee's health care. Per SB 5335, Sec. 202 (1)(b), employers' minimum required health care expenditure would be 10.5 percent of an employee's aggregate adjusted quarterly payroll or wages and less the employer's health care expenditures for that employee during the same reporting period. An

[25] *Golden Gate Restaurant Association v. City and County of San Francisco et al.*, Supreme Court of the United States, Case No. 08-1515. It was ruled that the program's requirement of employers in San Francisco to spend a minimum amount per hour on healthcare for their employees does not violate ERISA because it provides options for employers to comply with the requirement. Additionally, it is not specified what benefits employers must provide in their ERISA plans, nor are employers required to provide coverage through an ERISA plan. A timeline of the key events in the case can be found **here**.

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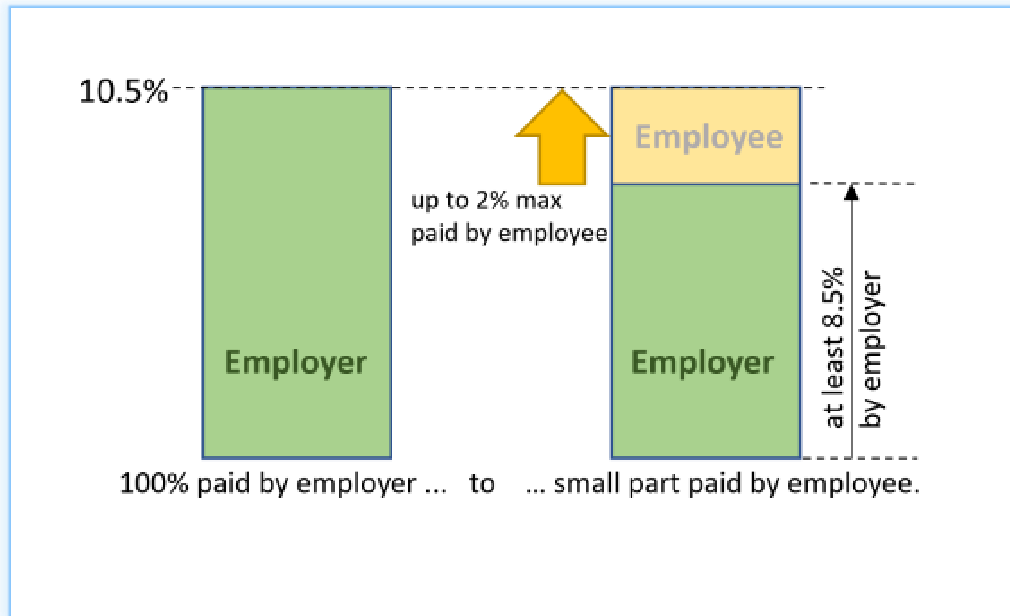
employer may elect to deduct up to two percent of the required health care expenditure from an employee's wages. This per-employee required health expenditure would serve as the means of employer revenue to support the Trust and is illustrated in Figure 1[26] below.

Figure 1: Employer/employee contribution



All licensed providers would be eligible to receive reimbursement for services from the Trust, but participation would be optional. Annually, the Washington Health Trust Board (Board),[27] in coordination with HCA, would collectively negotiate reimbursement rates with qualified providers[28] on a fee-for-service (FFS) basis.[29]

Alignment between the Commission and SB 5335 for self-funded employers

The Commisison and SB 5335 are aligned in the goal of providing access to coverage and care for Washingtonians who currently receive health care coverage through their employer. The Commission and SB5335 are also fairly aligned on how to integrate self-funded employers, depending on what the courts determine is legal. The Commission will further analyze options to integrate employees and employers once more design components of the universal system are determined. At that point, the Commission will also assess any unintended consequences, mitigatation strategies for inevitable legal challenges, health

[26] Figure provided by Whole Washington.
[27] As defined in Sec. 102.
[28] Not including providers participating as community health providers as defined in Sec. 102.
[29] Sec. 109 directs that provider rates are at the discretion of the Washington Health Trust Board and HCA and their established mechanisms permitting qualified providers to collectively negotiate budgets, payment schedules, and other terms and conditions of Trust participation.

equity impacts, and costs and/or savings to the state. Alignment between the Commission and SB 5335 can also be further assessed and determined at that time.

Table 2 below outlines areas of alignment between the Commission's preliminary eligibility work and SB 5335. Green represents alignment, yellow signifies some alignment, and gray signifies that determining alingment requires further analysis.

Table 2: Employer eligiblity areas of alignment

	Commission	SB 5335
Goal	Integrate employees and employers into Washington's universal health care system and generate revenue from employers to support a unified financing system.	
Transition /long term (Assuming no changes in federal ERISA law)	Voluntary employer participation in the universal health care system may help mitigate legal challenges.	Employers may choose between continuing to offer employees existing private coverage or to allow employees to receive coverage under the Trust.
Transition /long term (Assuming no changes in federal ERISA law)	Offering employers a meaningful alternative to their exisiting employee coverage has been successful in other cities/states and may, alongside other policy levers, survive an ERISA challenge.	Modeled after San Francisco's experience, the Trust aims to offer employers a meaningful alternative to their exisiting employee coverage.
Transition /long term (Assuming no changes in federal ERISA law)	Financial contributions from employers will be key to supporting and sustaining the universal health care system.	Modeled after San Fransisco, creates a per-employee required health expenditure to generate revenue to support the Trust
Transition /long term (Assuming no changes in federal ERISA law)	Provider regulation/incentives will be needed to achieve universality and to provide the state with levers to achieve feasibility of financing a universal system.	Voluntary provider participation, but all providers would be eligible to receive (and not be denied) reimbursement. Participating providers could collectively negotiate reimbursement rates with the authorizing entities.

Medicaid (Apple Health)

Given the significant role Medicaid plays in Washington's health care system, the number of residents who rely on Medicaid as their source of health coverage, and the complexity of the program rules, Medicaid will be a foundational component of the Commission's design for the universal system. While Medicare and ERISA present significant federal barriers, there may be a path forward for Medicaid.

Commission[30]

Medicaid is jointly financed by states and the federal government. CMS provides the rules and oversight with which states must comply in administering the program to obtain federal matching dollars through the Federal Medical Assistance (FMAP).[31 & 32 & 33]

The Medicaid program has the largest array of health benefits and long-term care and support services in comparison to employer-based coverage, individual market coverage, and Medicare. To receive FMAP funds, there are 15 mandatory benefits states must provide and 28 optional services that states may elect to cover.[34] Washington's Medicaid program, or Apple Health, provides all mandatory and all optional benefits depending upon the specific eligibility category. [35]

States can require certain groups of Medicaid beneficiaries to pay enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost-sharing amounts. However, the total amount of premiums and cost sharing incurred by all individuals in a Medicaid household may not exceed five percent of the

[30] See Appendix C for the Commission's eligibility assessment of Medicaid.
[31] The FMAP is computed by a formula that considers the average per capita income for each state relative to the national average. Washington's FMAP is 50 percent.
[32] To receive federal funding, states must cover certain "mandatory" populations in their Medicaid program. Medicaid mandatory populations include children through age 18 in families with income below 138 percent of the federal poverty level (FPL), certain parents or caretakers with very low income, people who are pregnant and have income below 138 percent FPL, seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.
[33] States may also receive federal Medicaid funds to cover "optional" populations. Medicaid optional populations include adults and children in the groups listed above whose income exceeds the limits for "mandatory" coverage, seniors and people with disabilities not receiving SSI and with income below the poverty line, "medically needy" people and other people with higher income who need long-term services and supports, with the Affordable Care Act (ACA) expansion, non-disabled adults with income below 138 percent FPL, including those without children. "Medically Needy" is a phrase used to describe optional coverage for persons who do not quality for Categorically Needy Medicaid programs due to income.
[34] All mandatory benefits must be provided to mandatory populations. Optional benefits may be provided to some, but not all, optional populations.
[35] States began to enroll most of their Medicaid clients in comprehensive, risk-based managed care arrangements beginning in the 1990s. These efforts were driven by many reasons, including a desire to provide more predictability over future state budget costs. Other reasons include greater accountability for outcomes, more support for systematic efforts to measure, report, and monitor performance, access, and quality, and the potential to improve care management and care coordination. More than 85 percent of Washington's Medicaid beneficiaries are enrolled in Medicaid Managed Care Organizations (MCOs).

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family's monthly or quarterly income.[36] Apple Health does not have any premium or point-of-service cost-sharing requirements.[37]

To include Medicaid beneficiaries in a unified financing system administered by the state, it will be necessary to change the relationship between the state and the federal government with respect to the implementation of the program. One way to make these changes is through demonstration waivers permitted by CMS.

States use 1115 waivers for broad authorities to carry out demonstrations or test new ideas that further the goals of the Medicaid program by doing something in a different way. Some examples of how states have used or are currently using 1115 waivers include:

- If federal law prevents a needed service or benefit[38]
- If federal law prevents a desired population from being covered[39]
- If federal law prevents certain program administration elements[40]

Section 1115 waivers are approved "at the discretion of the Department of Health and Human Services (DHHS) Secretary," must be budget neutral to the federal government, and must further the objectives of the Medicaid program.[41] The approval process can take years for complex waivers, including a review by the Office of Management and Budget.

Additionally, in its review process, CMS does not consider contingencies. For example, if a state applies for a Medicaid 1115 waiver that cross-references savings contingent on approval of a 1332 waiver related to Exchange coverage, CMS will not consider the projected savings from the 1332 waiver in determining whether the proposed 1115 waiver satisfies the budget neutrality requirement. Further, 1115 waivers

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[36] Cost-sharing can be applied to the following populations including pregnant women and infants with family income at or above 150 percent FPL, qualified disabled and working individuals with income above 150 percent FPL, disabled working individuals eligible under the Ticket to Work and Work Incentives Improvement Act of 1999, disabled children eligible under the Family Opportunity Act (FOA), and medically needy individuals.

[37] Washington's Children's Health Insurance Program (CHIP), the Medicaid program for children in households with incomes greater than 210 percent FPL, imposes modest premiums.

[38] Medicaid cannot pay for "Institutes of Mental Disease" (IMD), or inpatient mental health services at a designated facility, for patients aged 21-64, or substance-use disorder (SUD) treatment, as this may require an inpatient stay and states have used 1115 waivers to allow IMD services for SUD and mental health services.

[39] Medicaid cannot pay for health services for incarcerated individuals, except for inpatient hospitalization. Many states are seeking flexibility to provide services to individuals who are incarcerated as they approach their release date to support transitions to the community.

[40] Medicaid does not allow premiums except under certain circumstances. Some states have obtained 1115 waivers to apply premiums and co-pays to the ACA expansion population.

[41] Section 1115 research and demonstration waivers. Medicaid and CHIP Payment and Access Commission. **https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/**

require significant evaluation, reporting, and oversight to ensure program integrity and provide information about the impacts of the flexibilities they are testing.

Some states have sought eligibility expansions through State Plan Amendments (SPA). Compared to a waiver, a SPA would require a state to put up additional matching dollars and provide mandatory or optional benefits depending on the population. In addition, a SPA would be a relatively permanent change to a state's Medicaid program that wouldn't have to be renewed every five years (as a waiver does) and it creates an entitlement where all those who apply and enroll must be served all the benefits for that particular program. On the other hand, a waiver would allow for different benefit packages to expanded populations, allow for premiums and co-pays, and most importantly, allow a state to obtain credits for state spending (rather than allocate matching dollars) to finance the coverage so long as it is budget neutral to the federal government. States can use either a SPA or waiver to eliminate asset tests required in Classic Medicaid. Recently, Arizona has used a SPA while California is using its 1115 waiver to do so.

Ongoing discussion

The Commission's discussions regarding options to incorporate Medicaid in Washington's universal system continue. Additional questions/topics that will be important when considering how to incorporate Medicaid include:

- Given the lower Medicaid provider reimbursement rates relative to other payers like Medicare and commercial plans, at what rate will providers under the new system be paid, and how will continuing Medicaid providers be paid relative to the new rate?
- The effectiveness of MCOs in Medicaid compared to a different administrative model, e.g., Connecticut's transition from managed care to fee-for-service (FFS).
- Ensuring that the state can obtain all the information necessary to maintain federal match.
    - What needs to be done to make Washington's programs more seamlessly integrated, and what have other states done in this space?
- Accounting for supplemental payments that are made to hospitals and other providers that make Medicaid rates similar to Medicare.
- When considering increasing Medicaid rates, it is important to avoid simply defaulting to commercial rates because Medicare payments are generally adequate for cost-efficient hospitals.
- An actuarial analysis may be helpful to better understand benefit levels and provider reimbursement rate adequacy.

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SB 5335

SB 5335's goal is to provide equitable coverage through the proposed Trust for all, including those covered through Medicaid, and to maximize the use of federal funding in the Trust. Per SB 5335, development of a demonstration waiver to incorporate federal Medicaid funding into the Trust would be at the discretion of HCA. SB 5335 directs HCA to

> "Negotiate with the federal Department of Health and Human Services' Health Care Financing Administration to obtain a statutory or regulatory waiver of provisions of the Medicaid statute, Title XIX of the federal Social Security Act, and CHIP including, but not limited to, application for an applicable demonstration project."

As noted previously, Medicaid provider reimbursement can be significantly less than that of Medicare or commercial payers. This will need to be addressed in integrating the Medicaid program into a universal health care system supported by unified financing. Whole Washington, proponents of SB 5335, propose that the Trust would reimburse providers at an increased negotiated rate for all residents with hopes that advancing provider payment equity would also advance health equity for all patients.[42]

Alignment between the Commission and SB 5335 for Medicaid

The Commisison and SB 5335 are aligned in the goal of providing access to coverage and care for Washingtonians who currently receive health care coverage through Medicaid. However, the Commission aims to continuously analyze options to integrate Medicaid alongside their discussions regarding benefits and services and provider reimbursement for the new system. At that point, the Commission will also assess any unintended consequences, health equity impacts, and costs and/or savings to the state. More specific areas of alignment between the Commission and SB 5335 can also be assessed and determined at that time.

Table 3 below outlines areas of alignment between the Commission's preliminary eligibility work and SB 5335. Green represents alignment, yellow represents some areas of alignment, and gray signifies that determining alingment requires further analysis.

Table 3: Medicaid eligibilty areas of alignment

	Commission	SB 5335
Goal	Integrate Medicaid funding to support Washington's unified financing system.	
Transition	1115 waivers and SPAs may offer pathways to integrate federal Medicaid funding to support a unified financing system.	HCA is directed to negotiate with federal DHHS to obtain a demonstration waiver.

[42] Sec. 109 of SB 5335 directs that the Washington Health Trust Board of Trustees (Board) (established in Sec. 102), in coordination with HCA, must adopt rules and mechanisms to permit providers to collectively negotiate budgets, payment schedules, and other terms and conditions of Trust participation. Additionally, the Board, in coordination with HCA, must annually and collectively negotiate reimbursement rates with providers on a fee-for-service basis.

Long term	Utilize tools such as demonstration waivers and/or SPAs as appropriate to integrate federal Medicaid funding.	Utilize a federal 1115 waiver to integrate federal Medicaid funding.
Long term	Further analysis is needed to determine where Medicaid reimbursement rates should increase. This is especially important because lower Medicaid rates often disincentivize providers from participating in Medicaid, creating barriers to access for Medicaid patients.[43]	Reimbursement for all providers, including Medicaid providers, will be set at an increased rate (relative to the status quo) to be negotiated by the Board in coordination with HCA and providers participating in the Trust.

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Enrollment infrastructure

Commission and SB 5335

The Commission and SB 5335 share the goal of expanding or repurposing existing infrastructure where possible to support the state's transition to and implementation of a universal health care system. The Commission and SB 5335 have identified an existing health care coverage enrollment process which could be expanded to facilitate enrollment for the future system.

Alignment between the Commission and SB 5335

Currently, enrollment for both Apple Health (HCA's domain) and Qualified Health Plans, or QHPs (Exchange), is administered through a shared eligibility and enrollment system operated by the Exchange through Washingtonhealthplanfinder.com. Altogether, one out of four Washingtonians (over two million individuals) use this site to find health coverage and/or financial assistance to obtain health coverage. This enrollment system interfaces with other data sources to offer an integrated and streamlined application process for Washingtonians seeking health care coverage. HCA and the Exchange share the mission to offer a streamlined process for Washington residents to search, shop, enroll and obtain financial assistance to obtain health coverage and continue work to strengthen the shared Medicaid and QHP enrollment process.

Table 4 below outlines areas of alignment between the Commission's preliminary eligibility work and SB 5335. Green represents alignment.

Table 4: Enrollment areas of alignment

	Commission	SB 5335
Goal	Employ a user-friendly, efficient enrollment mechanism to enable all Washingtonians to enroll in the universal health care system.	

[43] Some providers, e.g., rural hospitals, receive Medicaid reimbursement at rates similar to that of Medicare and even commercial plans due to supplemental payments.

Transition	Strengthen existing enrollment infrastructure utilized for Medicaid and QHPs to prepare the state for the transition to a universal health care system.
Long term	Strengthen and expand existing enrollment infrastructure utilized for Medicaid and QHPs to faciliate enrollment for the universal health care system.

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Benefits and services

Background

One of the goals in designing a state-based universal health care system is to ensure that all Washingtonians receive comparable health care benefits and equitable access to care. After eligibility, the Commission selected benefits and services as the second design component of the new health care system to examine.[44]

Currently, there are varying levels of covered benefits across health care coverage sources and even within the same coverage source. For example, unlike Medicaid, Medicare does not cover vision, hearing, dental, or Long-Term Services & Supports (LTSS). However, individuals dually eligible for Medicare and Medicaid[45] could receive such benefits as supplemental coverage through Medicaid. Additionally, benefits offered under private coverage can vary. For instance, for coverage offered on the state's Exchange, provider networks and cost-sharing can vary by metal tier even under the same health carrier.

Commission

As previously noted, there are significant challenges to fully integrating the existing health care coverage sources into the new health care system, not the least of which are the quality and equity implications of varying benefits (particularly at the outset). The Commission aims to design a benefits package for the new system that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care, while recognizing that the more robust the benefits, the more costs could increase to the state at the outset.

In its early stages of benefit design, the Commission has looked to work that has already been done in this space. The Universal Health Care Work Group (Work Group),[46] predecessor to the Commission, recommended that the ACA-mandated categories of services defined in the Essential Health Benefits (EHB) be provided with the possibility of additional service categories, including vision. Among the outstanding considerations was whether other benefits not included in the EHB,[47] such as LTSS, would be provided.[48] Other states, including California and Vermont, also modeled their respective universal health care benefits after the EHB. Whole Washington also selected the EHB for SB 5335's benefit design, details of which will be covered later in this section. Conversely, Oregon selected their state's public employee/school employee plan for the basis of their state-based universal health plan.

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[44] In their **baseline report**, the Commission identified the following design components of a universal health care system: cost containment, coverage and benefits, eligibility, enrollment, financing, governance, infrastructure, and provider participation and reimbursement.

[45] Lower income Medicare enrollees may qualify for supplemental coverage and benefits through Medicaid.

[46] **Work Group Final Report**. 2021.

[47] The covered benefits under the EHB will be detailed in the section describing SB 5335's proposed benefits and services.

[48] All plans sold on the state and federal marketplaces must provide EHBs as well as any other services or supplies required by the state. Each state defines that plan, which is used as a benchmark for the state's essential health benefits. The **CMS website** provides details on Washington's benchmark plan.

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The Commission sought to compare covered benefits under some of the richer benefits packages under Medicaid and PEBB/SEBB's Uniform Medical Plan (UMP), however creating a tool to do so has proved challenging. For example, Medicaid provides benefits that are required by CMS to obtain federal matching dollars, and fully insured market plans must provide state-mandated benefits not required in the EHB. Given these challenges, the Commission enlisted FTAC's expertise on the approach for an actuarial analysis to compare benefits across Medicaid, UMP, and Washington's EHB.

As FTAC noted, there will be a high degree of overlap between the three, and general benefit design may not have much impact on the total cost of care. As such, the issues of interest for the actuarial analysis will be around the scope of services, allowed quantities of services (duration), and cost-sharing. FTAC agreed that the Commission should consider the following for an actuarial analysis:

- Begin with UMP or EHB and layer on additional benefits to be modeled.
    - Cascade Care (standard qualified health plans on the Exchange)[49] could serve as the starting point for the EHB to understand the cost-sharing impact on premiums across the Bronze, Silver, and Gold metal levels, and then assess whether Medicaid and UMP cover anything different.
- Other dimensions of benefit design should be considered in future discussions, including prior authorization, supplemental benefits outside of the universal plan's covered benefits, point of service cost sharing, and a standardized provider reimbursement rate.

FTAC's considerations and recommendations will be shared with the Commission at their April 14 meeting. The Commission's editing of this report will be underway at that time, so findings from the actuarial analysis, and additional discussions and decisions on benefits and services will be provided in the Commission's 2025 report to the Legislature.

SB 5335

The health care coverage proposed under SB 5335 is inspired by the World Health Organization's definition of universal health care coverage, where "all people have access to the full range of quality health services they need, when and where they need them, without financial hardship."[50 & 51] Text from SB 5335 describing Whole Washington's vision for coverage under the Trust is also captured below.

> "With the intent to start healing the wounds of generations of inequality and to ensure a future where health care is recognized as a basic right afforded to each resident, the people of the state of Washington declare their intention to create a single, primary nonprofit health financing entity called the Washington Health Trust. The Trust will simplify health care financing, eliminate administrative waste, respond to the health needs of each regional health district, and **guarantee all residents coverage of a comprehensive set of essential**

[49] In 2019, **Senate Bill 5526** established standardized plans and the public option on the Health Benefit Exchange.

[50] **World Health Organization's** definition of universal health coverage.

[51] Residents would also be free to obtain coverage for the health care benefits not covered under the Trust. The Trust does would not interfere with benefits related to Labor & Industries (L&I), Veterans Affairs (VA), or Indian Health Services (IHS) or their funding.

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health benefits without the burden of premiums, deductibles, copayments, or medical bills. "

The proposed coverage offered under SB 5335 is based on the covered benefits under the EHB and is outlined below. SB 5335 also includes language to explicitly cover certain populations and categories of care including gender-transition care, reproductive care, and individuals affected by the justice system.

EHB categories

- Hospital services, including inpatient and hospital-based outpatient care and 24-hour emergency services
- Ambulatory primary and specialty services, including preventative care and chronic disease management
- Prescription drugs, medical devices, and biological products
- Mental health and substance use disorder treatment services
- Laboratory and other diagnostic services, including diagnostic imaging services
- Reproductive, maternity, and newborn care
- Pediatric primary and specialty care
- Palliative care and end-of-life care services
- Oral health, audiology, and vision services[52]
- Short-term rehabilitative and habilitative services and devices
- Licensed naturopathic, acupuncture, and massage therapies

SB 5335 would also cover hospice and end of life care, and long-term care benefits at least at the standards of Medicaid coverage, though these benefits would not be offered at the outset. Rather, these benefits are intended to be phased in within four years of the Trust's implementation.

Revenue and financing

Revenue

The Trust's revenue sources would include an employer payroll tax, an employee payroll tax, a sole proprietorship tax, and a capital gains tax as outlined in Table 5 below.[53] This approach compared to the status quo is proposed to lessen the financial burden imposed on individuals, families, and employers.

Table 5: SB 5335 revenue structure

SB 5335 revenue contributions by population	
Employers[54]	10.5 percent of wages

[52] Oral health, audiology, and vision services are not required service categories under the ACA.

[53] The Capital gains tax was ruled by the 2023 Washington State Supreme Court as constitutional exempting the first $250,000. **https://dor.wa.gov/about/news-releases/2023/capital-gains-excise-tax-ruled-constitutional**

[54] Employers would collect a contribution for each employee. After an exemption, the employer contribution would be a total of 10.5 percent of gross pay. Employers could deduct up to two percent from the employee's wages. The exemption calculation is $15,000 less the gross pay multiplied by one quarter of one percent (.25%). The exemption would not apply for any gross pay above $60,000.

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Employees[55]	Up to 2 percent of wages payroll deduction
Self-employed individuals[56]	2 percent of earnings of wages
Investors[57]	8.5 percent of capital gains

This revenue structure assumes that Whole Washington's approach to integrate funding from self-funded employers, the Trust's primary source of revenue, would not be preempted by ERISA and would survive related legal challenges. Figure 3 illustrates the breakdown of the revenue contributions by population and Figure 4 provides examples of employer expenditures under the proposed revenue structure.

Figure 3: Breakdown of SB 5335 funding

[55] Employers would be assessed a payroll contribution and may choose to deduct a portion directly from employee's wages. After an exemption, the maximum amount an employer could deduct is two percent of the employee's gross pay. The employer may choose to pay some or all the payroll contribution as a benefit of employment. The exemption is $15,000 less gross pay multiplied by one quarter of one percent (.25 percent). The exemption would not apply for pay above $60,000. The employee deduction would not apply to employees 65 years or older.

[56] Self-employed individuals would be assessed an annual contribution on their earnings. After an exemption, the self-employment contribution would be two percent of adjusted net earnings. The exemption calculation is $15,000 less the adjusted net earnings multiplied by one quarter of a percent (.25%). The exemption would not apply for net earnings above $60,000.

[57]After an exemption, an 8.5 percent tax contribution would be assessed on net long-term capital gains (LTCG) for LTCG over $15,000. The tax would not apply to residential or home sales, agriculture income, or retirement accounts. The exemption calculation is $15,00 less the LTCG multiplied by one quarter of one percent (.25 percent). The exemption would not apply for any LTCG above $60,000.

Figure 4: Examples of employer expenditures

10.5% with up to 2% paid by employees - Graduated exemption: $3,750 - (25% of total quarterly pay)

Employee's Gross Annual Pay	Earning Percentile	Employer Contribution (8.5-10.5%) per month	Max Employee Contribution (0-2%) per month	Employers Total Required Health Spending per Employee / month
Up to $12,000		$0	$0	$0
$20,000	<25%	$73.83 - $87.50	$0 - $16.67	$87.50
$40,000	25th	$247.91 - $306.25	$0 - $58.34	$306.25
$60,000*	**50th**	**$425.00 - $525.00**	**$0 - $100**	**$525.00**
$100,000		$708.33 - $875.00	$0 - $166.67	$875.00
$275,000	90th	$1,031.25 - $2,406.25	$0 - $1,375.00	$2,406.25

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Financing SB 5335

Whole Washington projects[58 & 59] that the greatest cost reductions for a new system would be realized by consolidating the existing public-private coverage into a new publicly funded and publicly administered health care system like that described in the Work Group's Model A (state administered).[60] However, SB 5335 describes a period where the Trust, beginning as Model B (state-designed plan privately administered),[61] would progressively transition to Model A over approximately five years. As such, the cost-savings projected under Model A would not be achieved any sooner than five years from the time of the Trust's implementation.

The Work Group's Models A and B are perhaps proxies in principle for the Trust's transitional path from the status quo, through Model B, to Model A. However, the Work Group's projected cost savings for Model A, the Trust's ultimate destination, does not compare with SB 5335's economic analysis of the same model. The Work Group and Whole Washington used different methodologies to project cost savings, however it is unclear whether the differing methodologies are the sole reason for such discrepancies. At the writing of this report, the Commission has not assessed in depth the discrepancies between SB 5335's economic analysis and the Work Group's. This can be assessed further in the Commission's continuing work to analyze SB 5335.

[58] Gerald Friedman, PhD. SB 5335 Economic Analysis. 2021. **https://wholewashington.org/friedman-financial-analysis-2021/**

[59] The Work Group also projected the greatest cost reductions under a publicly financed and publicly administered health care system.

[60] More details on the Work Group's proposed Model A can be found starting on page 23 of the Work Group's 2021 **final report**.

[61] More details on the Work Group's proposed Model B can be found starting on page 32 of the Work Group's 2021 **final report**

Alignment between the Commission and SB 5335

The Commission and SB 5335 align on the desire to design a new health care system with a benefits package that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care. Table 6 below outlines areas of alignment between the Commission's very early benefits and services discussions and SB 5335. Green represents alignment and gray signifies that determining alingment requires further analysis.

Table 6: Benefits and services areas of alignment

	Commission	SB 5335
Goal	A benefits package that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care	
Transition	Not yet discussed	Comprehensive coverage based on the EHB under the ACA (*not* including LTSS) with no cost-sharing.
Long term	Not yet discussed	Comprehensive coverage based on the EHB under the ACA, including LTSS with no cost-sharing.

In addition to designing a benefits package, the finance experts on the Commission's FTAC caution that more work must be done now to address overall health care spending in Washington to make any new system financially viable and sustainable.[62] In their benefits discussions and with the findings of the actuarial analysis, the Commission will need to decide on whether cost-sharing will be incorporated in the new system. SB 5335 explicitly opposes this idea, though most Washingtonians would be paying for their health care through a new tax.

SB 5335's economic analysis names health care administration as the greatest source of waste and inefficiency in the existing system. For example, the administrative costs for private insurers account for roughly 17 percent of operating expenditures, compared to only two percent under Medicare fee-for-service (FFS).[63] While it is true that Medicare maintains much lower administrative costs compared to private health carriers, it is important to note the distinction that private health carriers often maintain administrative functions not provided by Medicare FFS. For example, Medicaid Managed Care Organizations (MCOs) can provide case management and care coordination for enrollees.

Whole Washington agrees that private health carriers are not the sole contributor to higher health care costs, nor are they the only opposition to universal health care. FTAC asserts that increasing health care expenditures are driven largely by consolidation which drives price increases which drives spending. Since

[62] FTAC has noted that increasing costs are resultant of price increases driven by consolidation.
[63] Archer, D. Medicare Is More Efficient Than Private Insurance. **Health Affairs**. 2021.

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Washington's health care system is highly consolidated,[64] FTAC has stressed that addressing rising health care expenditures should be an immediate focus of the work to design a new system.

Whole Washington's economic analysis relies on various assumptions and the Commission will need to progress in their design of a new universal system and continue to engage with Whole Washington to determine whether the Commission's modeling will share those underlying assumptions. Having broader participation and consensus on a cost analysis will also lend credibility to these ongoing discussions, and the Commission anxiously awaits the findings of their actuarial analysis on benefits across the three payers identified.

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[64] Washington State's health care system has seen significant horizontal consolidation and vertical integration across health care providers, facilities, and insurers over the last three decades. Washington Office of the Insurance Commissioner **Preliminary Report on Health Care Affordability**. November 29, 2023.

Conclusion

SB 5335 offers eligibility and enrollment proposals not dissimilar from the Commission's early work, and the Commission will be better able to assess alignment with regards to benefits and services as work on this topic progresses. The Commission will continue to create opportunities to connect with Whole Washington to further assess elements of SB 5335 not captured in this report. The Commission would again like to thank the leaders and members of Whole Washington for their collaboration and important contributions to this report.

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Appendix A – Assessment of options to include Medicare

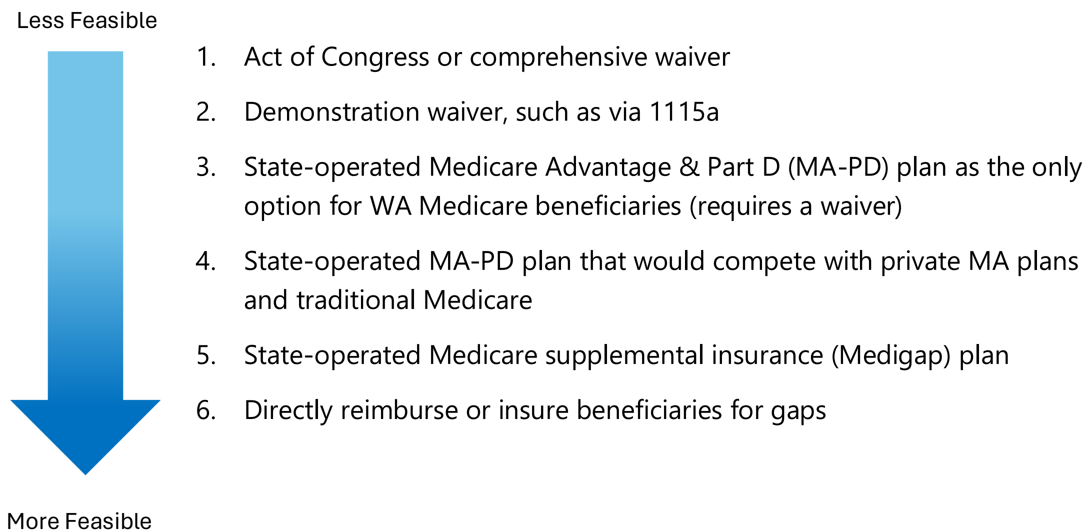
The feasibility of various components under each option was assessed by FTAC and is illustrated in Table 1. Based on this assessment, the six options ordered from least feasible to most feasible (Figure 1) and additional pros and cons of each option were examined by FTAC.

Table 1: Feasibility considerations for options to include Medicare

	Captures federal funding	Waiver or law change required	Level of federal oversight	Preserves beneficiary choice	Covers premiums	Covers cost-sharing	Covers non-covered services
1. Act of Congress	Yes	Yes	Unknown	No	Unclear	Possibly	Possibly
2. Demo waiver	Yes	Yes	High	No	Unclear	Unclear	Unclear
3. MA, only option	Yes	Yes	High	No	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates
4. MA, competes	Yes, for enrollees	Probably not	High	Yes	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates
5. State Medigap	No	Probably not	Medium	Yes	No	Yes	No
6. Reimburse directly	No	Probably not	Low to Medium	Yes	Yes, if covered	Yes, if covered	Yes, if covered

*Most options would also place an administrative burden on the state.

Figure 1: Options for incorporating Medicare ordered from least to most feasible



Options to include Medicare in Washington's future universal health care system

Option 1: act of Congress or comprehensive waiver

Option 1 is an act of Congress or a comprehensive waiver granted by CMS, which, if obtained, would allow Washington to enroll all Medicare enrollees into the universal system design and leverage federal funding,[1] a key advantage of this option. However, there is no legal precedent for such, and it is unlikely to be achieved via legislation through the current Congress. Moreover, Medicare enrollees may still experience some premiums.

A comprehensive waiver represents the "North Star," or ideal approach to addressing gaps in affordability and coverage for Medicare enrollees in the universal system, however pursuing Option 1 at this time is not an effective use of resources or time due to the significant federal barriers. Additionally, some members noted that CMS is unlikely to grant a waiver to a new and untested program.

Members recommended that the Commission focus on designing the new system and examine other transitional options to provide coverage and affordability parity for Medicare enrollees, rather than attempting to bring Medicare into the system from the outset.[2] It was also suggested that Washington consider actively partnering with Oregon to examine this option when Oregon's new governance structure[3] overseeing the universal health care system becomes operational.

Option 2: demonstration waiver

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[1] This option was used to calculate potential costs and savings of Model A by the Universal Health Care Work Group.

[2] There was some discussion about the potential benefits of contracting with a law firm as California did to better understand necessary preparations to obtain a federal waiver or possible legislative pathways.

[3] Oregon Universal Health Plan Governance Board.

Option 2 would require Washington to obtain an 1115 Medicaid waiver[4] or a 402b Medicare waiver. These waivers are generally focused on Medicaid-related payment and delivery system reforms (1115) or Medicare payment-related reforms (402b). These waivers must be cost-neutral to the federal government and not compromise the quality of the existing program.

This option would allow the state to capture federal funding, however because these waivers are designed for other purposes, it is unclear how this option could be leveraged to cover premiums, cost-sharing or additional benefits for Medicare enrollees. These waivers also involve significant oversight and evaluation by the state throughout implementation that would result in administrative costs and budget neutrality requirements. Additionally, there is no precedent for granting these waivers to achieve Washington's objectives. Finally, there is a possibility that even if granted by CMS, these waivers would be subject to legal challenges.

FTAC members agreed that Option 2 is not viable for achieving the goals of the universal system given that the intent of these waivers differs from what the Commission is trying to achieve. However, this option could complement the work being done via the universal health care system in areas such as cost containment and payment reform. Other areas of potential opportunity for the Commission to address payment reform include 2023 legislation (ESSB 5187) directing the Attorney General Office and Office of the Insurance Commissioner (OIC) to study market consolidations and anticompetition and hospital global budget strategies.[5, 6]

Option 3: state-operated Medicare Advantage & Part D (MA-PD) plan as the only option for Washington Medicare enrollees

This option would involve designing and implementing a MA-PD plan for Washington's Medicare enrollees that, to the extent MA rules allow, would provide benefits parity with Washington's universal system. Under Option 3, the state's MA plan would be the only MA option for Washington's Medicare enrollees.[7]

Members noted several disadvantages to this option. Obligating MA enrollees to enroll in only the state MA plan would require a federal waiver from the provision that allows for choice and to preclude other MA plans from entering the market. This option would also involve resolving payment structures, as MA payments are tied to Medicare's fee-for-service (FFS) benchmark compared with whatever payment structure is utilized in the universal system. Another disadvantage to this option is the administrative costs the state would incur to develop, implement, and oversee an MA plan, or to contract to do the same. Finally, this option could be subject to legal challenges if Medicare enrollees are prevented from accessing traditional Medicare.

FTAC members agreed that it was difficult to envision how the state could legally implement this option given the unlikeliness of obtaining a waiver that would limit freedom of choice. Members recommended not expending resources and time on this option, especially at the outset. Some members felt that this

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[4] This waiver from CMS would waive Section 1115 of the Social Security Act

[5] Sec.126(33) and Sec.144(13). https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003

[6] Some members recommended that any payment reform activity be done in consultation with the Health Care Cost Transparency Board.

[7] There are currently 18 carriers offering 100 MA plan types.

option could serve as a pathway in the future once the value of the program has been established. It was noted that the state would likely face downside risk, as the state would likely be reimbursed by CMS on a per-member-per-month basis. Finally, several members expressed concerns regarding the implications of disallowing Medicare enrollees to remain in traditional Medicare or in their current MA plan.

Option 4: state-operated MA-PD plan that would compete with private MA plans and traditional Medicare

Option 4 involves the same scope of work for the state to design and implement an MA plan with many of the same limitations as Option 3. However, under Option 4, the state's MA plan would compete with other private MA plans, where Medicare-eligible Washingtonians wishing to enroll or continue coverage with traditional Medicare could do so. This option does not limit Medicare enrollees' choice, potentially lessening the threat of legal challenges.

FTAC's response to this option was mixed. In addition to the administrative burden of designing and implementing the model like Option 3, the main concern with this option is the competition the state would face by entering a mature MA-PD market with multiple carriers offering over 100 MA plans. Additionally, Medicare-eligible Washingtonians may be inclined to renew existing coverage or could select options other than the state's, limiting the potential of federal dollars and the overall impact of this option.

However, FTAC did not recommend this option being completely removed as a possibility. There may be a possibility for this option to sit alongside Option 6 (direct reimbursement of insurance for gaps) in the future.

Option 5: state-operated Medicare supplemental insurance (Medigap) plan

Under Option 5, the state would develop and offer a Medigap plan to fill gaps in benefits between Medicare and the universal health care system. This option would allow the state to offer benefits to Medicare enrollees that are not covered under Medicare. However, Medigap plans do not cover benefits for hearing, vision, and supplemental drug coverage, which does not align with the Commission's goals for the universal system design. Moreover, the state would be limited in its ability to reduce Medicare enrollees' Part B deductibles with this option.[8] Finally, this option would not be available to MA enrollees, nor allow the state to leverage federal Medicare dollars.

FTAC members acknowledged that this option seemed feasible in terms of existing legal authorities and may be the least administratively burdensome to the state to implement. However, there were concerns that this option could not fully address benefits gaps between Medicare and any universal system design because of the extensive and complex regulatory requirements of Medigap plans. Additionally, like Option 4, this offering would require the state compete with other plans in a mature market and would not leverage federal funds. There was some interest in this idea as a possible short-term option, potentially paired with Option 1 or 2 in the long-term. However, the majority of FTAC members did not support Option 5 at this time.

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[8] Individuals eligible for Medicare on or after January 1, 2020 cannot purchase Medigap plans that cover the Part B deductible, or Plans C or F. https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

Option 6: directly reimburse or insure Medicare enrollees for gaps

Option 6 would establish a system to directly reimburse enrollees for cost-sharing and for services covered by the universal system but not by Medicare. This option allows the most flexibility to fully address gaps and would not require waivers nor result in legal challenges. Disadvantages to this option include the potential variances between Medicare enrollee choices, with federal rules potentially limiting the ability to wrap around Parts A & B. This option could also invite gaming from MA plans and may be administratively burdensome for the state and consumers. Finally, this option does not allow the state to leverage federal Medicare dollars.

FTAC members agreed that at this time, Option 6 presents the best option and most feasible pathway to address gaps in cost-sharing and benefits for Medicare enrollees. There was interest in learning more about the nuances of Option 6 and how it might be developed in the short-term to ensure parity.

FTAC members agreed that revisiting Option 6 with further analysis and decision-making will need to occur after the Commission has determined the services and benefits of the new universal system design. Until then, further analysis to determine what gaps need to be filled between existing Medicare services and benefits, and the services and benefits of the new system design is not possible. It was also noted that while federal dollars would not fund these additional benefits, placing the financial burden on the state, this option could be explored in conjunction with one of the waiver options to secure federal funding and/or as a means of payment reform or cost containment.

Additional Medicare considerations for the Commission's consideration

There were additional suggestions offered by FTAC members related to improving cost-sharing and services for Medicare enrollees, mainly through expanding eligibility for the Medicare Savings Program (MSP) and increasing eligibility for dual Medicare/Medicaid beneficiaries.[9] An additional option to expand services for low-income Medicare beneficiaries could be expanding Medicaid Categorically Needy coverage, which would provide full scope Medicaid coverage, including long-term care.[10] These additional considerations were intended to inform the Commission's future discussions about potential transitional solutions that improve coverage available for Washingtonians today that may help pave the way for the universal health care system of tomorrow.

The Commission's vote on Medicare

While a comprehensive waiver (Option 1) is the most beneficial option and the "North Star" for achieving the goals of a universal health care system supported by unified financing, this option lacks federal authority to implement. FTAC recommended to the Commission that direct reimbursement (Option 6) as the most feasible option for the short term to achieve coverage parity for Medicare enrollees which could be explored in conjunction with one of the waiver options. However, this requires further analysis. FTAC recommended that the Commission determine benefits and services and come back to this discussion to explore whether to pursue a waiver, rather than pursuing a waiver at the outset.

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[9] The 2023 legislature took action to expand MSP by appropriating $6.3 million, removing asset tests and increasing the Qualified Medicare Beneficiary (QMB) program from 100 to 110 percent of the federal poverty level.

[10] WAC 182-501-0060(6) lists the general categories of Categorically Needy services. All medically necessary services are covered.

In reviewing FTAC's guidance, one Commission member expressed concerns with adopting FTAC's recommendations on Medicare eligibility given that some questions regarding larger system design, such as benefit design, have not yet been addressed. However, as some Commission members noted, the guidance is not set in stone, but having this guidance allows the Commission to move forward in their design work. FTAC was also directed to examine this topic early in the Commission's design work to identify whether the assumption should be that a Medicare waiver could be obtained at this time. The Commission voted to adopt FTAC's guidance in the Medicare Memo (seven for, one opposed).

Appendix B - Assessment of the Employee Retirement Income Security Act of 1974 (ERISA)

Employers serve as a large source of health care coverage for employed Washingtonians, making integration of employers especially important for the financial viability of Washington's universal health care system. However, federal law exempts very large employers from state regulation. While incorporating large employers will be a particularly difficult feat, without them, Washington's future health care system will be neither sustainable nor universal.

Overview of ERISA

Washington can regulate fully insured individual and group health plans. However, the Employee Retirement Income Security Act of 1974 (ERISA) law preempts state regulation of self-funded employer health benefit plans.[1] While ERISA was not intended to be a health care statute, it is practically applied as one because of its preemption clause regarding state laws. ERISA, a federal statute, governs employers sponsored health care plans or insurance plans when an employer covers the full financial risk of its employees' claims for health care benefits (known as self-funded group health plans). Regulation of ERISA plans is "exclusively a federal concern" and preempts "all state laws insofar as they…relate to any employee benefit plan."

ERISA preemption is one of the broadest preemption clauses ever written and Washington is constrained in its ability to regulate employer benefits or achieve benefits parity between employer benefits and the future system. Pathways for capturing revenue, such as employer contributions, to support the unified financing system must be thoroughly examined.

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[1] Federal ERISA law sets minimum standards for health plans established and funded by employers to provide health care to their employees. Employer health plans can be "fully insured" or "self-funded". Both types of these health plans must comply with ERISA. However, the state's role varies based upon whether a plan is fully insured or self-funded. An employer that offers a fully insured health plan is paying for premiums to a health insurer and the insurer bears the financial risk of coverage. An employer that offers a self-funded health plan has chosen to bear the financial risk of health care services used by their employees, and often will contract with an outside entity to administer their health plan (called "third party administrators" or "TPAs"). The ERISA statute exempts these plans from most state regulations.

Examination of employer (ERISA) integration by other states

The Commission's strategic plan for 2023 included gathering information from other states and current programs in Washington. Other states, including Oregon and California have examined prospects for ERISA integration for their respective and future state-based universal health care systems; details of which are summarized below. This section also includes efforts in Washington to achieve universal access to specific health benefits across all insurance markets while avoiding an ERISA challenge.

California

Established in 2019, the Healthy California for All Commission (HCAC)[2] was charged with developing a state-based health care delivery system that provides coverage and access for all Californians through a unified financing system, including, but not limited to, a single-payer system. HCAC's 2022 final report[3] examined the conflicts between unified financing proposals and ERISA law. HCAC noted that a state-based unified financing system cannot be achieved without federal support, but that unlike Medicare and Medicaid, "ERISA does not contain any waiver provisions to allow state-level health reform experimentation."

HCAC largely relied on a publication by Erin Fuse Brown and Elizabeth McCuskey, experts on ERISA law, for clarity on available options to integrate employers into California's single payer proposal.[4] Several states have introduced legislation for a unified health care financing system. Between 2010-19, more than sixty single-payer bills, including models with which to avoid ERISA preemption, were introduced in 21 state legislatures. While no universal health care system/plan has passed into law[5] and thus no ERISA models have been tested in court, the three ERISA models most advanced by legislators proposing single-payer bills over that period include:

1. Economic incentives – Use payroll taxes, income taxes, or both to raise revenue to pay for the universal plan.[6]
2. Provider regulations - Restrict providers participating in the universal plan from billing any third party other than the universal plan.
3. Assignment/subrogation/secondary-payer provisions - Allow the universal plan to pay for services and then seek reimbursement from patients' employer-based health plans.[7]

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[2] Senate Bill (SB) 104 (Chapter 67, Statutes of 2019).
https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB104

[3] Appendix D. ERISA Considerations for Unified Financing. Key Design Considerations for a Unified Health Care Financing System in California. April 2022. **https://www.chhs.ca.gov/wp-content/uploads/2022/05/Key-Design-Considerations-for-a-Unified-Health-Care-System-in-California-Final-Report.pdf**

[4] Fuse Brown, E. C., & McCuskey, E. Y. (2019). Federalism, ERISA, and State Single-Payer Health Care. U. Pa. L. Rev., 168, 389. **https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3395462**

[5] Excluding Vermont's abandoned **Green Mountain Care**.

[6] This approach is designed to incentivize employers/employees to drop employer coverage (or offer supplemental coverage for benefits not covered under the universal plan) to avoid having to contribute to both the universal plan and employer coverage.

[7] Brown and McCuskey noted the courts' historical reading of the statutes that do not conform with the original Congressional intent of ERISA and offered four possible solutions at the congressional and courts levels to achieve goals for state-level unified financing and that avoid an ERISA challenge. The first three options are congressional amendments and include replacing the "any and all" preemption with floor

Brown and McCuskey noted the courts' historical reading of the statutes that do not conform with the original Congressional intent of ERISA. With paths to action by Congress and the courts on ERISA uncharted and unpredictable, the authors recommend states utilize a combination of economic incentives, provider regulation, and assignment/subrogation/ secondary-payer provisions. This approach stands the greatest chance of avoiding ERISA preemption in states' efforts to integrate employers into a state-based universal plan/system.

Oregon

In their 2022 Final Report and proposed Universal Health Plan (Plan),[8] Oregon's Joint Task Force on Universal Health Care (Task Force) chose to combine several elements to consolidate employer and employee spending on health care into the Plan. These elements include:

(1) A payroll tax levied on all employers
(2) Restrictions on coverage duplication by state-regulated health insurers
(3) Regulation of participating provider reimbursement.

Like California, the Task Force enlisted the expertise of Brown and McCuskey to assess ERISA preemption issues in their Plan. Brown and McCuskey affirmed that when combined, the elements above would likely survive ERISA preemption. Additionally, this approach would still encourage employers and employees to shift to the Universal Health Plan.

Brown and McCuskey also offered that Oregon may be in especially good standing to integrate employers and employees and thus fund their Plan. An excerpt from Brown and McCuskey's analysis of this point is included below.

> "The Ninth Circuit Court of Appeals, which covers Oregon,[9] has particularly strong precedent upholding states' ability to enforce payroll taxes to fund public health care programs. Ordinances passed by the cities of San Francisco and Seattle required employers to contribute to public programs that would cover their employees if the employers did not offer their own coverage. The Ninth Circuit held that these so-called "pay-or-play" laws created economic incentives for employers, but not to the point that they would effectively force the employer to start or stop offering particular benefits.[10] While these ordinances calculated the taxes on employers in part based on the employers' benefit choices, the Ninth Circuit held that the establishment of a public-program alternative preserved the employers' benefit choices enough to avoid preemption."

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preemption (which is used in other comparable health statutes), eliminating ERISA's "deemer clause" thus removing barriers around interference with self-funded employer-based plans under ERISA, and adding a statutory waiver provision to ERISA. The fourth proposed option is new jurisprudential interpretations that curtail the courts' vision of ERISA's preemption.

[8] Joint Task Force on Universal Health Care Final Report and Recommendations. Prepared by the Legislative Policy and Research Office. September 2022.

[9] The Ninth Circuit also covers Washington State.

[10] Golden Gate Restaurant Association v. City and County of San Francisco, 546 F.3d 639, 642 (9th Cir. 2008); ERISA Indus. Comm. v. City of Seattle, 840 Fed. Appx. 248 (9th Cir. 2021).

FTAC's discussion and guidance on ERISA options for Washington

The Commission's goal in designing a universal health care system is to include the employer-based market[11] without running afoul of ERISA preemption because without it, the universal plan is neither "universal" nor fiscally sustainable. The Commission directed FTAC to examine several components of ERISA in addition to surfacing options to include employers in Washington's future system.

Approximately one-third of Washingtonians are covered by ERISA plans. This means that any state laws passed by the Washington Legislature related to employer health benefits could be preempted by ERISA in relation to these plans; therefore, careful consideration of ERISA is necessary in the Commission's efforts to design a universal system with equitable benefits for all Washingtonians.

With the understanding that large employers must be included and will be impacted by universal health care implementation, FTAC examined large employer perspectives on state-based universal health care.[12] With a belief that the ability to design and offer health care coverage helps differentiate in competition for talent, large employers would fiercely defend ERISA.[13]

Some large employers may believe that they can do a better job for their employees than the government would and generally resist what they perceive to be intrusive government regulation, such as price-setting, while acknowledging that the costs associated with providing these benefits is increasing. However, large employers generally will accept government intervention in areas where no market exists or areas where the market has failed irreparably, e.g., drug price controls. This information also helped identify ways that universal health care could be made appealing or acceptable to large employers, including administrative simplicity, better cost control, and employers' participation in the universal health care system being optional.

Following this presentation, law professor Erin Fuse Brown, an ERISA expert who has advised both Oregon and California's universal health care efforts, described some potential options for designing a system that would achieve the policy goal of including as many employers as possible (including self-funded plans) and would be more likely to survive a challenge brought under ERISA. [14] Professor Fuse Brown's presentation focused on the potential impact of ERISA on three models of a universal coverage system:

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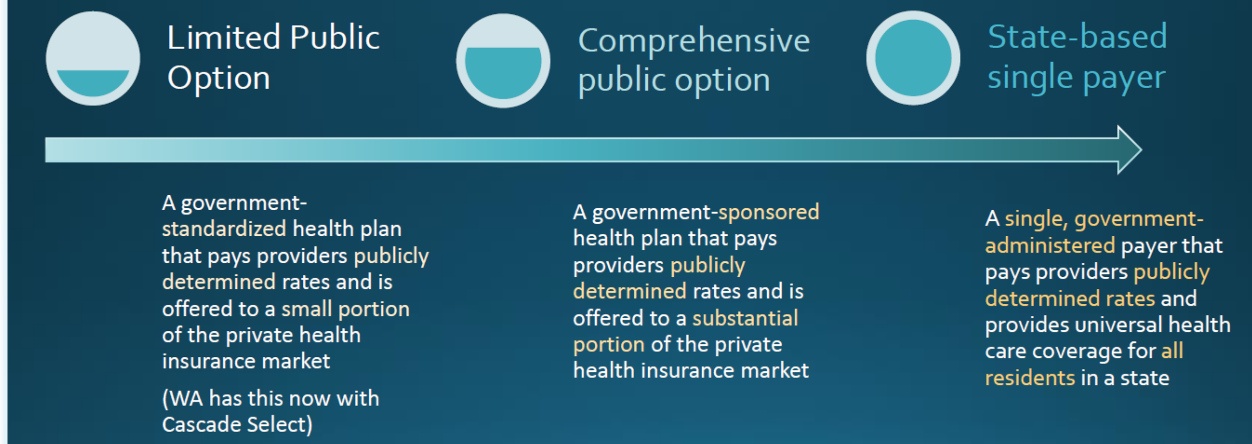
[11] Employer-based health care coverage accounts for 52 percent of Washingtonians' health coverage. Data are from OIC internal carrier enrollment reports (using 2021 reports), the American Community Survey's health insurance coverage tables, and Kaiser Family Foundation (KFF) self-insured data. The estimate of individuals in self-funded group health plans is based upon the calculation of known enrollment and national estimates from KFF annual employer health benefit survey and others. Health Coverage Estimates in Washington. 2021. OIC.

[12] Presentations by Bill Kramer and Erin Fuse Brown, JD, MPH, can be found in **FTAC's September meeting recording.**

[13] The **ERISA Industry Committee** is an example of an organization whose goal is to protect ERISA preemption.

[14] Professor Fuse Brown introduced her presentation with an overview of the Affordable Care Act (ACA) requirements of large employers. Employers with 50 or more full-time employees must offer affordable/minimum value medical coverage to their full-time employees and their dependents or face



Erin Fuse Brown's presentation to FTAC, September 14, 2023

Following this, FTAC discussed six options for how to include employers in Washington's universal health care system and avoid ERISA preemption. A summary of each option and FTAC's guidance to the Commission is included in the sections below.

Options to include ERISA in Washington's future universal health care system

Option 1. Federal waiver at this time.

As Professor Fuse Brown made clear during her presentation, there is no authority in the ERISA statute for a federal administration to waive any provisions in ERISA. Specifically, the U.S. Department of Labor, which enforces ERISA, has no authority to waive its provisions. This is unlike the waiver authorities granted to CMS under Medicare and Medicaid. Therefore, only an act of Congress could eliminate or modify ERISA preemption, which would allow UHCC to design a system that includes universal enrollment and mandatory participation by employers and providers. As an example, the ACA included an "employer mandate" which requires all large employers to provide minimum essential coverage that is affordable, offers minimum value, or if it fails to do so, to pay a penalty for each full-time employee who receives a subsidy and purchases coverage on an exchange. This provision is not preempted by ERISA because the ACA is a co-equal federal law.[15]

Similar to FTAC's discussion of Medicare options, FTAC quickly determined that no waiver is possible and that pursuing an act of Congress is not feasible at this time. One FTAC member recommended that the

penalties. https://www.irs.gov/affordable-care-act/employers/affordable-care-act-tax-provisions-for-large-employers

[15] The employer mandate can be waived by the federal government via a 1332 waiver.

Commission partner with Oregon and California to develop federal legislation to allow states' incorporation of large employers into their respective unified health care financing systems.

2. Optional employer participation

Option 2 would provide that all employers (including self-insured and fully-insured employer-based plans) have the option to pay for their employees to be covered by the universal health care system. Employers would also remain free to provide their own self-funded health coverage. The goal with this option would be to develop a universal health care system that would be attractive enough that employers would forgo offering their self-funded plans because joining the universal system would be less expensive, reduce employers' administrative burden, and make it easier for employees to obtain the health care they need at lower costs to them. An advantage to this option is that it would not be vulnerable to a challenge under ERISA since it does not interfere with employers' freedom to offer their own plans. However, if significant numbers of employers choose to continue offering their own plans, the universal system would not be able to recoup employer expenditures as part of its financing. Additionally, the universal system's risk pool would be adversely affected since employees in self-funded plans tend to be healthier compared to the rest of the population.

FTAC members agreed that optional employer participation should be included as one part of the design of the universal system. They also discussed ways to finance the universal system to address the problems raised by this option, as discussed below.

3. Pay or play

Under this option, employers are given a choice: they can choose to pay a tax, which could be in the form of a payroll tax or a tax on revenue, or they can continue to offer their own health coverage. If they continue to offer their own coverage, they are exempted from the payroll tax ("Pay or play"). This option is likely to survive an ERISA challenge but would be less likely to provide an incentive for employers to forgo offering their employer-based plans. FTAC members agreed that "pay or play" is an option that should be further explored to be considered in the design of the universal system.

3a. Meaningful alternative (comprehensive public option)

An extension of "pay or play," a meaningful alternative, or an alternative to employers' current coverage, could be structured as a comprehensive public option as outlined by Professor Fuse Brown. This option, more expansive than Washington's current public option program, Cascade Select, is focused on designing a plan that offers an option for Washingtonians that employees could opt into. FTAC members expressed support for designing a meaningful alternative that could eventually attract employers, or even serve as a glide-path to a single-payer system.

4. Provider regulation/incentives

This option concerns ways to provide incentives to health care providers to accept patients covered by the universal system, the idea being that as providers migrate toward a state-sponsored plan, employers would follow. They include provisions requiring providers to accept patients under the new system while also being able to contract with other plans, or to accept only such patients if they choose to accept them. These provisions do not raise any concerns under ERISA, although there may be other legal

considerations that were beyond the scope of FTAC's discussion. Requiring providers to contract with the universal plan without the ability to contract with other plans may be preempted by ERISA. This option does not capture revenue and would therefore need to be combined with another option to create a sustainable system. This option also includes ways to reduce costs to make the system more financially sustainable, such as rate caps or rate regulation.

There was broad agreement among FTAC members that provider regulation/incentives must be a part of the design of the universal system, not only to achieve universality in principle, but also to provide the state with levers to achieve feasibility of financing a universal system in practice. Further analysis and discussion will be needed to expand upon this option, to understand specific policy requirements, political hurdles, and cost impacts.

5. Payroll tax on all employers

Under this option, a payroll tax would be levied on all employers. While employers would be free to continue to offer their own plans to their employees, there would be no exemption from the obligation to pay the tax for those employers who choose to do so (so-called "Pay and play"). Professor Fuse Brown offered the analogy that all homeowners are required to pay property taxes which fund public education. They are free to send their children to private schools but remain obligated to pay their property tax. Whether this option would be preempted by ERISA is uncertain and it would depend on whether the courts viewed the payroll tax to be "exorbitant." [16]

More than one FTAC member recognized that this option could be useful in obtaining the necessary funding for the universal system. Additionally, it is not tied directly to providing health care and may be less likely to trigger an ERISA challenge. In this context, the explicit focus is not on compelling employers to participate, but rather on obtaining funding for the system. FTAC members were interested in further exploring what payroll tax structure could be considered palatable by employers and not "exorbitant" by the courts to obtain funding in the future.

6. Combination of two or more options

The options discussed above are not mutually exclusive, and two or more could be combined. FTAC members agreed that a combination of Option 2, (giving employers the option to continue providing self-funded plans) coupled with Option 3a (providing a meaningful alternative to employers' current coverage) that incorporates components of Option 4 (strategies to require or incentivize provider participation while reducing costs), should be part of the universal system. This approach is focused on designing a system that would offer a meaningful alternative to what employers offer currently that would be available to Washingtonians with strategies to address access and cost. It is not yet clear the best method of capturing employer contributions and incentivizing them to permit their employees to enroll in the universal system.

FTAC members agreed that a combination of options represents the most promising approach. A final determination of the best policies to pursue will depend on decisions about the structure of the universal

[16] There is no set threshold for when a tax becomes "exorbitant" for ERISA preemption purposes. However, in *New York State Conference of Blue Cross & Blue Shield Plans et al. V. Travelers Insurance Co. et al*, the Supreme Court found that a 24 percent surcharge on commercial insurance claims to hospitals was not exorbitant. **Travelers, 514 U.S. 645**.

health plan that the Commission has not yet considered, so that the ERISA issue will need to be addressed again when further design on the system is complete. Legal challenges may be inevitable which would create delays in implementing a universal system, and a combination of approaches that includes options that are not likely to be challenged could ensure some aspects of reform could be implemented without delay.

The Commission's vote on ERISA

The Commission understands that unlike the waiver authorities granted to CMS under Medicare and Medicaid, there is no such authority in the ERISA statute. However, including employers and employees is necessary to ensure that Washington's universal health care system is indeed universal and fiscally sustainable. FTAC recommended to the Commission that a combination of the above policy levers should be part of the universal system. However, legal challenges may be inevitable, and this requires further analysis. One Commission member raised concerns with adopting FTAC's recommendations regarding a payroll tax on all employers regardless of whether they offer employees health benefits, referring to the aforementioned Ninth Circuit's upholding of San Francisco and Seattle's establishment of respective public-program alternatives that preserved employers' benefit choices enough to avoid preemption. Removing the option for employers to offset their current benefit expenditures against the tax could expose the state to more legal risks under ERISA. As some Commission members noted, the guidance is not set in stone, but having this guidance allows the Commission to move forward in their design work. The Commission unanimously voted to take under advisement FTAC's guidance on ERISA in their universal health care system design work and to revisit the ERISA topic, including the employer payroll tax, once more design elements are developed.

Appendix C – Medicaid eligibility assessment

Given the significant role Medicaid plays in Washington's health care system, the number of residents who rely on Medicaid as their source of health coverage and the complexity of the program rules, FTAC members were provided several presentations focused on Medicaid over the course of their November 2023 and January 2024 meetings. Presenters at the November meeting included Joan Altman, Commission member and Director of Government Affairs and Strategic Partnerships for the Washington Health Benefits Exchange (Exchange), Melissa Rivera, Lead Policy Manager for Eligibility from the Washington State Health Care Authority (HCA), and FTAC member Roger Gantz. Presenters at the January meeting included Dan Meuse, Deputy Director of the Advancing Coverage in States and State Health and Value Strategies Program at Princeton, Mich'l Needham, Chief Policy Officer for the State Health Care Authority and Steven Spivak, PhD.

Medicaid topic areas covered

Shared Enrollment Systems

During the November meeting, Joan Altman, Commission member and Director of Government Affairs and Strategic Partnerships for the Exchange offered an overview about how enrollment for Medicaid (referred to as Apple Health in Washington) and Qualified Health Plans (QHP) is administered through a shared eligibility and enrollment system operated by the Exchange through Washingtonhealthplanfinder.com. Altogether, one out of four Washingtonians (over two million individuals) use this site to find health coverage and/or financial assistance to obtain health coverage. Ms. Altman was joined by Melissa Rivera from HCA who offered more information about how these systems work and interface with other data sources to offer an integrated and streamlined application process for Washingtonians seeking health care coverage. She also shared information about the Exchange's efforts to improve affordability for QHP customers through the state's public option plans, Cascade Select. Ms. Rivera provided additional information about the work that HCA and the Exchange are doing together to lead statewide efforts to maintain coverage for eligible individuals during the public health emergency unwind. This presentation conveyed the shared mission and experience between HCA and the Exchange to offer a streamlined process for Washington residents to search, shop, enroll and obtain financial assistance to obtain health coverage.

Ms. Altman and Ms. Rivera were followed by FTAC member Roger Gantz, who gave a comprehensive overview of Washington's Medicaid program, including eligibility categories, federal financing, benefits and services, cost sharing, and program administration.

Financing

Medicaid is a jointly financed and administered program where the federal government through the Centers for Medicare and Medicaid Services (CMS) provides the rules and oversight of the program that states must comply with in administering the program to obtain federal matching dollars through the Federal Medical Assistance Percentage (FMAP). The FMAP is computed by a formula that considers the average per capita income for each state relative to the national average. Washington's FMAP is 50 percent.

Eligible Populations

To receive federal funding, states must cover certain "mandatory" populations in their Medicaid program:

- Children through age 18 in families with income below 138 percent of the federal poverty level (FPL);
- Certain parents or caretakers with very low income;
- People who are pregnant and have income below 138 percent FPL;
- Seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

States may also receive federal Medicaid funds to cover "optional" populations:

- Adults and children in the groups listed above whose income exceeds the limits for "mandatory" coverage;
- Seniors and people with disabilities not receiving SSI and with income below the poverty line;
- "Medically needy" people and other people with higher income who need long-term services and supports;[1]
- With the Affordable Care Act (ACA) expansion, non-disabled adults with income below 138 percent FPL, including those without children.

Benefits

To receive FMAP funds, there are 15 mandatory benefits states must provide and 28 optional services that states may elect to cover. All mandatory benefits must be provided to mandatory populations; optional benefits may be provided to some, but not all, optional populations. Apple Health provides all mandatory and all optional benefits depending upon the specific eligibility category. The Medicaid program has the largest array of health benefits and long-term care and support services in comparison to employer-based coverage, individual market coverage, and Medicare.

Cost-Sharing

States can require certain groups of Medicaid beneficiaries to pay enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost-sharing amounts. However, the total amount of premiums and cost sharing incurred by all individuals in a Medicaid household may not exceed five percent of the family's monthly or quarterly income. Cost-sharing can be applied to the following populations:

- Pregnant women and infants with family income at or above 150 percent FPL;
- Qualified disabled and working individuals with income above 150 percent FPL;
- Disabled working individuals eligible under the Ticket to Work and Work Incentives Improvement Act of 1999;
- Disabled children eligible under the Family Opportunity Act (FOA);
- Medically needy individuals.

Washington's Medicaid program does not have any premium or point-of-service cost-sharing requirements. Washington's Children's Health Insurance Program (CHIP), the Medicaid program for children in households with incomes greater than 210 percent FPL, imposes modest premiums.

Program Administration

States began to enroll most of their Medicaid clients into comprehensive, risk-based managed care arrangements beginning in the 1990s. These efforts were driven by many reasons, including a desire to

[1] Medically Needy is a phrase used to describe optional coverage for persons who do not quality for Categorically Needy Medicaid programs due to income.

provide more predictability over future state budget costs. Other reasons cited included greater accountability for outcomes, more support for systematic efforts to measure, report, and monitor performance, access, and quality, and the potential to improve care management and care coordination.

While the shift to MCOs has increased budget predictability for states, the evidence about the impact of MCOs on access to care and costs remains limited. More than 85 percent of Washington's Medicaid enrollees are enrolled in Medicaid Managed Care Organizations (MCOs).

Waivers

To include Medicaid enrollees in a universal financing system administered by the state, it will be necessary to change the relationship between the state and the federal government with respect to the implementation of the program. One way to make these changes is through waivers permitted by CMS.

At the January meeting, Dan Meuse from Princeton provided an overview of waivers states could seek that would allow them flexibility in how they operate their Medicaid programs while maintaining federal matching funds.

Mr. Meuse explained that states use 1115 waivers for broad authorities to carry out demonstrations or test new ideas that further the goals of the Medicaid program by doing something in a different way, while 1915(b) waivers allow for limits in service providers and 1915(c) allows for service comparability for home and community-based services. He offered several examples of how states have used, or are currently using, 1115 waivers including:

- If federal law prevents a needed service or benefit:
    - Medicaid cannot pay for "Institutes of Mental Disease" (IMD) – inpatient mental health services at a designated facility – for patients aged 21-64.
    - Substance-use disorder (SUD) treatment may require an inpatient stay and states have used 1115 waivers to allow IMD services for SUD.
- If federal law prevents a desired population from being covered:
    - Medicaid cannot pay for health services for incarcerated individuals, except for inpatient hospitalization. Many states are seeking flexibility to provide services to individuals who are incarcerated as they approach their release date to support transitions to the community.
- If federal law prevents certain program administration elements:
    - Medicaid does not allow premiums except under certain circumstances (covered in the presentation by Roger Gantz). Some states have obtained 1115 waivers to apply premiums and co-pays to the ACA expansion population.

Mr. Meuse further explained that Section 1115 waivers are "at the discretion of the Health and Human Services" Secretary," must be budget neutral to the federal government and must further the goals of the Medicaid program. He emphasized that the approval process can take years for complex waivers, including a review by the Office of Management and Budget.

Other considerations offered by Mr. Meuse were that in its review process, CMS does not consider contingencies. For example, if the state applies for a Medicaid 1115 waiver that cross-references savings contingent on approval of a 1332 waiver related to Exchange coverage, CMS will not consider the projected savings from the 1332 waiver in determining whether the proposed 1115 waiver satisfies the

budget neutrality requirement. He also reminded FTAC that 1115 waivers require significant evaluation, reporting, and oversight to ensure program integrity and provide information about the impacts of the flexibilities they are testing.

Mr. Meuse gave examples of how 1115 waivers have been used to expand Medicaid eligibility to limited populations including:

- Incarcerated individuals 30-90 days pre-release
- Post-partum individuals
- Individuals with SUD
- Individuals up to 200 percent FPL
- Caregivers of children
- Seniors with mental health needs

Mr. Meuse shared that New Mexico recently heard from CMS that it would be allowable to expand Medicaid to 400 percent FPL.

State Plan Amendments vs. Waivers

Some states have sought expansions through State Plan Amendments (SPA), including the District of Columbia which has expanded Medicaid to people with incomes up to 215 percent FPL. Compared to a waiver, a SPA would require the state to put up additional matching dollars and provide the mandatory or optional benefits depending on the population (as noted in Roger Gantz's earlier presentation). In addition, a SPA would be a relatively permanent change to the state's Medicaid program that wouldn't have to be renewed every five years (as a waiver does) and it creates an entitlement where all those who apply and enroll must be served all the benefits for that particular program. On the other hand, a waiver would allow for different benefit packages to expanded populations, allow for premiums and co-pays, and most importantly, allow the state to obtain credits for state spending (rather than allocate matching dollars) to finance the coverage so long as it is budget neutral to the federal government. One question the Commission asked FTAC to consider when looking at Medicaid eligibility is whether states need a waiver to eliminate the asset test for certain individuals who are in Classic Medicaid. Mr. Meuse shared that either tool could work to eliminate the asset test and gave Arizona as an example of a state that's using a SPA while California is using its 1115 waiver to do so.

HCA's Chief Policy Officer Mich'l Needham offered insights into Washington's experience applying for and obtaining waivers from CMS. She described key steps in the process including developing a concept paper describing the state's idea (often informed by legislative direction); data collection; completeness review; Tribal consultation; public comment and negotiations. Large and complex waivers can take a significant amount of time to negotiate. For instance, Washington's recent 1115 renewal was negotiated for a year before some components were approved. Additional information was provided regarding the work required after waiver approval including a sizeable amount of program implementation activities and reporting requirements by the state.

Provider Reimbursement and Medicaid Rates

FTAC heard from Dr. Steven Spivak who described a study he co-authored while at Yale University (published in *Health Affairs*) about the characteristics of primary care providers who do not accept Medicaid patients and some potential policy interventions. The study found that in a survey of 1,731 primary care practices, 17 percent had no Medicaid revenue. Practices with no Medicaid revenue were on average smaller, independent, had a higher proportion of primary care physicians in the practice,

were more likely to be urban, in low poverty areas, and in states that did not expanded Medicaid. Some of the common reasons identified for not accepting Medicaid included:

- Organizational capabilities and infrastructure;
- Access to a large enough patient base outside of Medicaid;
- Less advanced population health and IT capabilities;
- Hesitancy among providers to accept patients who rely on Medicaid as their source of health coverage.

Dr. Spivak identified some suggestions that the FTAC/Commission might consider to increase the number of primary care providers accepting Medicaid including:

- Increase reimbursement rates;
- Focus efforts on smaller, independent practices and what they need (e.g., streamlining billing and administrative requirements, timelier claims processing, more technical assistance);
- Target efforts to practices residing in areas with more individuals receiving Medicaid may be more likely to move from the 0 percent to >0-10 percent category;
- Harness power of consolidated systems and managed care.

FTAC Discussion

Following the presentations at the November meeting, there was a question about whether the state will need to continue requiring a significant amount of eligibility information for Medicaid enrollees to obtain federal matching funds even with an 1115 waiver. FTAC members agreed that yes, this requirement would likely to be maintained. However, the shared Medicaid/QHP enrollment platform establishes a strong foundation that can be leveraged to gather this information.

FTAC members also identified additional questions/topics that will be important when considering how to incorporate Medicaid including:

- What is the effectiveness of MCOs in Medicaid compared to a different administrative model, e.g., Connecticut's transition from managed care to fee-for-service (FFS)?
- How do we ensure that we are able to obtain all the information necessary to maintain federal match? What needs to be done to make our programs more seamlessly integrated, and what have other states done in this space?
- If we are looking at uniform benefits that look the same across Medicaid, commercial, etc., what about cost-sharing?
- How do we account for supplemental payments that are made to hospitals and other providers that make Medicaid rates similar to Medicare?
- When we consider rate normalization, it will be important to be cautious in simply defaulting to commercial rates because Medicare payments are generally adequate for cost-efficient hospitals. In addition, for some rural hospitals, Medicaid supplemental payments are available and result in payments that in some cases exceed commercial rates.

In general, FTAC members expressed the need for additional information, noting that an actuarial analysis may be helpful to better understand benefit levels and provider reimbursement rate adequacy.

There was some discussion about whether managed care did or did not improve access for individuals enrolled in Medicaid. Dr. Spivak shared that a recent study found that post ACA expansion, providers who were already accepting Medicaid patients accepted more, while those who did not, continued not to. This was observed in both FFS and for those enrolled in Medicaid managed care. Discussion of the

pros and cons of managed care versus FFS and the design elements that would be common to both and desirable under any unified system were outside the scope of FTAC's ask from the Commission.

There was continued discussion about how Medicaid rates would need to be addressed as part of the universal design but that it was not essential in the consideration of whether FTAC could make a recommendation about Medicaid as part of the universal system. FTAC member Roger Gantz shared a memo with the committee in advance of the January meeting outlining other considerations related to what is necessary in a waiver application to implement the future universal system design, which is included in the background materials to the Commission. FTAC felt it would be important to revisit this memo, considerations, and the questions above as the Commission continues to discuss the universal system design in the future.

Recommendations

FTAC surfaced pathways to include Medicaid in the universal system. FTAC's recommendations provide guidance to allow design work to advance, though Medicaid will need to be revisited over the course of the Commission's design work for the larger system.

Washington's Medicaid program provides the richest benefit of any payer and could be something to aspire to for coverage under Washington's universal health care system (though members largely agreed that including LTSS as a covered benefit is not likely – at least not at the start). Administrative processes would need to change to integrate Medicaid into a unified financing system. FTAC members agreed that both 1115 waivers and SPAs should be considered as tools to achieve this and other policy goals.

Recommendation #1: Pursue Medicaid Waivers and State Plan Amendments as needed to include Medicaid in the universal health care system

After much discussion, FTAC agreed that including Medicaid financing is essential to the universal health care system design and that seeking flexibilities through waivers and state plan amendments as needed is critical to achieving the Commission's objectives. The proposed vote language was broadened from focusing simply on 1115 waiver to waivers and state plan amendments in recognition that some elements may be achievable without waivers or in advance of waivers and that waivers are only one tool in the toolbox to achieve the goal of universal coverage with a uniform financing system. FTAC can provide guidance on the basis for any waiver(s) or state plan amendment(s) in the future, should the Commission choose to pursue these tools. FTAC suggested revised language for a vote which is outlined below.

FTAC Vote:

Recommend that the Commission consider pursuing Medicaid waivers and state plan amendments as needed to include Medicaid enrollees in Washington's universal health care system, details of which will be developed once benefits and services and other design components are determined.

Recommendation #2: Evaluate the Role of Medicaid Rates and Access to Care for Washington Enrollees

FTAC recognized that low Medicaid reimbursement rates are often cited by providers as the primary reason they do not accept Medicaid patients. It is true that Medicaid rates are lower than what Medicare or commercial insurance pays for comparable services. However, there are often

supplemental payments for some providers (e.g. Federally Qualified Health Centers (FQHCs) and hospitals) that must be considered in determining where Medicaid provider reimbursement rates present a challenge for providers and reduced access for Medicaid enrollees. FTAC agreed with the Commission that increasing Medicaid rates would be important for a unified system and noted that doing so would require the Washington Legislature to allocate funding for the state's share of the federal match. FTAC also expressed concern that a limited or targeted approach to increased Medicaid rates at this time is premature and that more information is needed. As such, they suggested revised language below.

Proposed FTAC Vote:
Recommend that in advance of any recommended provider rate increase for Medicaid, the Commission recommend a study to evaluate the impact of Medicaid rates on access to care for Washington Medicaid enrollees.

Recommendation #3: As Part of Transitional Solutions, Focus on Administrative Simplification for Medicaid to Help Motivate Provider Participation

Another important factor that may impact whether providers are willing to serve Medicaid patients is the administrative complexity in serving the population. One of the core areas the Commission has selected to focus on in 2024 is administrative simplification (as part of its charge to make recommendations about transitional solutions). As such, FTAC offered a recommendation that this work evaluate how administrative simplification efforts could help motivate provider participation in the Medicaid program.

FTAC Vote:
Recommend that in their transitional solutions work, the Commission consider paths to simplify administration for the Medicaid program which may help motivate provider participation in Medicaid.

The Commission's discussion on Medicaid

FTAC's guidance was provided to the Commission at their February meeting. The Commission agreed with FTAC that benefits and services will need to be determined before more work can be done on the finer points of how to include Medicaid. The Commission also agreed that continuously revisiting Medicaid in conjunction with determining other design elements will be important, considering the nuances of the Medicaid program, e.g., lower provider reimbursement, richer benefits package, etc.

Feedback on UHCC draft legislative report on SB.5335

Prepared by Andre Stackhouse in consultation with members of Whole Washington, Health Care For All Washington, and other universal healthcare advocates.

Introduction

Washington's Universal Health Care Commission (UHCC) was asked by members of the Washington legislature to conduct an analysis of Senate Bill 5335, a statewide single-payer healthcare reform bill also known as The Washington Health Trust (WHT). The commission has agreed to submit their report by June 30th 2024.

The request aligns with the commission's chartered work to study universal health care proposals and recommend policy to the state legislature.

UHCC has shared a draft of their report and has requested our review and feedback of it - this feedback document must be submitted to the UHCC by April 12th 2024.

Link to annotated draft report:
https://docs.google.com/document/d/1tjI3aZDsDILmZk4eoSAs3QtaFKOcn5Qb/edit

Whole Washington would like to thank the UHCC for being given three opportunities to present to the UHCC about the design and projected impact of the WHT. We would also like to thank the UHCC for committing to this analysis and report and for sharing an early draft with us with an open request for feedback. It is only through an open, transparent, inclusive, and public process that we can build the trust and consensus necessary to guide Washington state through the inevitably challenging and consequential transition to universal public healthcare.

This feedback document has been compiled in collaboration with coalition partners and leaders from the grassroots universal public healthcare movement within and outside of Whole Washington.

Executive Summary

- **We appreciate that UHCC has committed to conducting this analysis** and is producing this report.
- **We appreciate being included** as presenters and having this draft shared with us for feedback.
- We appreciate the breakdown of considerations into categories and the rating of alignment between UHCC's goals and SB.5335.
- We appreciate that **the breakdown so far identifies no points of strong misalignment**, disagreement, or incompatibility between our goals and work.
- We believe that there are many helpful points of analysis worthy of explicit note and in some cases further analysis.
- We include a section for community comments to give more general/overall feedback.

- We believe that some conclusions written in this report reflect personal, political, or industry biases that are worthy of correction and have done our best to identify those points with a correction or challenge.
- We believe this report lacks a strong point-of-view necessary to sufficiently set public expectations on the future work of the commission.
- We believe this report lacks clear recommendations to either the legislature or the public. Below are some questions that we believe are worth having UHCC answer explicitly even if it is necessary to vote.
    - **The UHCC recommends that the Washington Legislature reintroduces the WHT in the 2025 session with the following changes and then resubmitted to the UHCC for review - yes/no/abstain**
        - List recommended policy changes below
- **We would like to know the authors of this report.**
- **Many of the claims require citation whether factual or in reference to positions of the UHCC and FTAC.**
- In discussion with our community and partners there was a fair amount of consensus that **the commission may need more time** to produce a more comprehensive report that can more effectively answer questions and move our work forward.
    - We may suggest extending the deadline of this report though no formal decision was made on this yet.
    - We would like to hold to the June 30th 2024 deadline for at the very least a progress report or interim report.
- **Whole Washington remains available** for further feedback, meetings, presentations to the commission, and any other form of expertise or help that we can provide to the UHCC.

Public Comments

Feedback from members of the universal public healthcare community

- **Kathryn A. Lewandowksy, BSN, RN, Whole Washington Board Vice-Chair**: I want to say that I feel that this report is quite biased. Frequently in the report it makes comments that some of the Commission's questions need to be answered in the beginning of a section and then at the end provides the answers to their own questions. I am especially disappointed at the reference below. I do not find anywhere in Dr. Friedman's financial analysis that the trust anticipates healthcare costs to be doubling. And it is also false that Dr. Friedman does not show any evidence for improving outcomes. Although possibly intended to mislead people reading the document, I feel that it is clearly an untruth. More importantly, the commissioners are making no recommendations to members of the legislature for taking any actual action towards achieving their goals.
- **Cris Currie, BSN, MA, HCFA-WA Member**: I could spend many more hours documenting more examples of clear bias, inaccurate characterizations, cherry-picking quotes out of context to support a predetermined view, and wasted meeting time on irrelevant presentations, but the point is that these HMA consultants are determined to move as slowly as possible and make everyone believe that single-payer is completely infeasible. They clearly know very little about single-payer health systems (with Liz even even admitting she is only somewhat familiar with 3 other states when there are 19 actively engaged in single-payer proposals) and they therefore should have no further role in facilitating this Commission.

- **Jen Nye, Whole Washington Communications Lead**: A report that identifies areas of alignment is not particularly useful if the Commission's work itself is not clearly defined. Our end goal should be passage of ***publicly-funded*** universal health care legislation, and therefore, we should shift away from comparing SB 5335 and the work of the Commission, to instead focusing on recommendations for viable legislation. The audience and end user of any UHCC report is the Washington State legislature and governor, and the start of the next legislative session is fast-approaching. My hope is that 5335 could be used as a template for what to recommend, improving and editing it as needed. And while I appreciate all the work put into this, my concern is that we're not getting closer to a defined goal.

Challenged Language & Assertions

Questionable facts, problematic language, unfair framing

- *Elements of the Washington Health Trust proposal not captured in this report will continue to be assessed in collaboration with Whole Washington and will be included in the Commission's annual report beginning in 2025 until the analysis is complete.*
  - We acknowledge that more time may be needed in order to conduct sufficient analysis to answer every important question about SB.5335.
  - We acknowledge that this is a draft and will likely see sufficient expansion and revision by June 30th 2024.
  - However, we believe that withholding further analysis from beginning until the November 2025 report and running "until the analysis is complete" 1) Delays the beginning of work for too long (the work has begun and must remain ongoing) and 2) Sets too indefinite of a timeline for this work.
  - While there remain areas of ambiguity we believe there is sufficient information in the record for the UHCC to begin making decisions and commitments with regards to SB.5335 and its design components.
  - We are requesting feedback and action that will allow us to meaningfully incorporate that feedback into our legislative work in the 2025 session.
  - We need as much of this report completed as possible by the November 2024 report - this gives us time to incorporate that report into 2025 legislation.
- *Specifically, this report includes an assessment of whether elements of the proposal align with the goals and planned activities of the Commission, including: Eligibility, Enrollment, Benefits & Services*
  - We have worked to use the Commission's identified design components in our language and presentations and believe they have been helpful in providing a framework for this discussion.
  - However, being assessed on alignment between the Commission and the design proposed in the WHT on these components is strange because to our understanding the Commission has not voted to confirm its position on any of these components. This makes it difficult to understand for instance what it means for there to be "alignment" between UHCC and WHT on something like Benefits & Services - WHT defines its covered benefits but it is unclear if UHCC currently has a position on Benefits & Services to align with.
- *As directed by the Legislature, the Commission must, "**Implement immediate** and **impactful changes** in the state's **current health care system** to increase access to quality, affordable health care … **reducing fragmentation** of **health care financing** across multiple public and private*

*health insurance entities … **reducing unnecessary administrative costs** … establish the preliminary infrastructure to **create a universal health system**, including a **unified financing** system … once the necessary federal authorities have been realized."*

- We appreciate the appeal to the original legislation that defines the Commission's purpose.
- We maintain that many of the design components of the WHT qualify as immediate and impactful changes that can and should be implemented immediately.
- We would like to make note that despite the talk time it got in some of our discussions with UHCC, that we were at no point asked to present on political feasibility or price/cost controls. However, we believe that WHT and our testimony in its support have directly addressed many of the core goals articulated in SB.5399.
- We agree that while federal action and cooperation is necessary to fully realize the vision of the WHT or a "Model A" system of any kind, that more emphasis needs to be made on the solutions that are proposed as currently feasible without federal action. WHT does not require federal waivers to be passed into law or to begin in its implementation. We believe that there are immediate and impactful changes ready for implementation today.

- *As requested by members of the Legislature, this report will focus on areas of alignment between the Commission and SB 5335.*
  - We do not agree that this is a complete summary of the request from Senators Hasegawa and Cleveland. Further elaboration in the **Missing/Further Analysis** section.
- *SB 5335 recognizes that in the long term, integration of federal Medicare dollars would be essential to supporting and sustaining the Trust.*
  - SB.5335 is designed to work without the integration of federal Medicare dollars and our interpretation of Friedman's analysis
- With regards to ERISA, the likelihood of employers maintaining their self-funded plans, and the odds of a losing court ruling, we disagree with the Commission's pessimism and believe that these claims in particular require citation. Much of this we consider unknown and to some extent unknowable but we do not believe we should be making assumptions here. We know that Healthy San Francisco survived its ERISA challenge and that we modeled WHT's design after it. The Ninth Circuit Court of Appeals ruled that Health SF did not violate ERISA and is the same circuit court that would evaluate the WHT. Secondly, while we do not have exact statistics, the city-option established with Healthy San Francisco has achieved widespread employer participation and has been steadily providing healthcare to uninsured and low-income recipients since 2007 with no additional federal waivers or funding from federal programs. As far as we can tell it coexists quite effectively alongside Medicaid and Medicare in California.

Missing/Further Analysis

Questions we'd like answered but still aren't

- The following items were identified as key deliverables of this report in the April 11th Universal Health Care Commission meeting and are summarized in the meeting minutes. The four below points we believe have not yet been sufficiently addressed by the contents of this draft report.
  - **Assess whether the proposal aligns with the goals and planned activities of the Commission.**
  - **Assess whether and how the Commission might recommend implementing the proposal.**

    - **Assess if the Commission considers it within their mission and a viable proposal.**
    - **Inform Senators Hasegawa and Cleveland of areas of the bill that fall outside of the Commission’s current work.**
- What are the guiding principles that the UHCC is using to evaluate SB 5335? Why have they not been clearly stated in the report?